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Redirecting Resources to Community Based Services: A Concept Paper

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Abstract

A legacy of the command economy in Central and Eastern Europe and the former Soviet Union is a social protection system that emphasizes institutional care for vulnerable individuals. It has been well established that in many cases institutionalization can be more expensive per client served and produce inferior welfare outcomes than more inclusive approaches designed to support individuals within their families and communities. But countries seeking to change the model of services face a number of financial constraints, including redirecting resources away from institutions. How can countries develop the new programs in an affordable manner? How should they change the financing flows to support the new options, without putting the burden of financing on the vulnerable themselves? The objective of this paper is to provide a framework to help countries re-orient their financing systems for social care. The paper first reviews key concepts in social care financing and then applies them to the problem of changing social care models in ECA countries.

TABLE OF CONTENTS

TABLES AND BOXES

EXECUTIVE SUMMARY

One of the legacies of the command economy in Central and Eastern Europe and the former Soviet Union is the development of a social protection system for vulnerable individuals focused on institutional care. It has been well established that the approach of removing a child or an adult from the family and the community is more expensive per client served than more inclusive approaches which are designed to support individuals within their own families and communities, main streaming them as much as possible. Institutional approaches also produce worse outcomes than community-based approaches for most individuals.

Countries seeking to change the model of social protection services have faced a number of constraints. Financing new programs requires first and foremost redirecting resources away from institutions. If countries want to develop the supply of new programs, how can they do so in an affordable manner? How should they change the financing flows to support a menu of new options, better tailored to the needs of individuals and without putting the burden of financing on the vulnerable people?

The objective of this paper is to provide a framework to help countries re-orient their financing systems for social care, so that they can implement a change program for the social care system. The ultimate objective is that countries use more family-based and inclusive care programs, and use institutional care as a last resort, thus supporting families to care for their vulnerable members rather than place them in residential care programs. Family-based and inclusive care programs are generally more effective in meeting social needs and, at least on a unit cost basis, less expensive.

Changing the financing system – although necessary -- is not sufficient to achieve the goal of less institutionalization. Other components of a change program would include reforms to ensure quality of provision such as standards and accreditation, training, information to clients, monitoring, etc., and those which improve the gatekeeping and needs assessment process, including rigorous outcome and impact evaluation. The effectiveness of the financing framework in doing its job is determined in part by the effectiveness of these other policy reforms.[1] This paper: (a) reviews key concepts in social care financing; and (b) applies them to the problem of changing social care models in ECA countries.

SOCIAL CARE FINANCING CONCEPTS

What are social care services? Social care services are services supplied to vulnerable individuals and families to help them out of poverty and exclusion, and live a full and satisfying life. Vulnerable individuals are usually considered to be disabled, frail elderly, people at risk of abuse or deprivation of basic needs, or children deprived of parental care or mistreated in their family.

Social care services are a support for everyday living. They should be a complement to: (a) services provided by families, and (b) other public services (health care, education, housing, employment assistance and training, etc. justice, etc.). A broad range of services may be provided. Institutional care is only one of the possible products, and it should be used very infrequently.

What is the public sector role? Families usually do not have the financial resources to buy these services or to provide them directly. They often need professional advice on choosing the service package (as with health care). In principal, social care services could be privately insurable. However, there are major problems in

[1] Concept papers on reforming gatekeeping and developing standards are also available. See Bilson and Gotestam (2002) and Harwin and Bilson, (2002).

developing an insurance market in this sector, including the classic insurance problems of adverse selection and moral hazard. Vulnerability tends to be correlated with poverty, so the demand is greatest among those least able to afford insurance – implying that some public subsidy is needed. It has been observed that as national income increases, the demand for these public finance for these services increases. Public finance is seen as the best substitute for inefficient and ineffective private insurance markets.

Public finance for social care services immediately creates problems of rationing. The public sector has to ration the financing available, prioritizing needs and resources so that public financing is directed to ensuring access to services for those with the greatest need, and to those services that produce the best outcomes. If a good rationing system is not in place, those most in need are likely to find themselves without services. Rationing requires technical knowledge and training to perform the needs assessment and service matching, and often the assistance of a social worker or other trained specialist is needed to select the service and monitor the result. In the case of children, especially children deprived of parental care, social care almost always requires someone to act on the child's behalf. This person is called an *agent* for the individual or family in need (*the principal*). The agent acts as one of the gatekeepers to the system, rationing care.

The public sector plays a major role in organizing the supply of services. This is done by either: (a) directly supplying the service; (b) contracting out the supply of the service to a monopolist private or NGO supplier according to service standards; and/or (c) by setting standards for service provision by a competitive private sector.

What is the role of the financing framework? The financing framework has a critical role in regulating the supply and demand for social care services. A good financing framework:

- ensures that demand, as determined by the gatekeeper and the agent or the individual, is financed so that care is rationed properly, so that those most in need receive access to services which have the high benefits, and
- provides incentives so that the providers supply services efficiently and at a high quality.

In other words, one of the key tasks of the financing system is to try to align the incentives of the system. *The financing framework is one of the key public policy tools to ensure access, cost-effectiveness and quality in the social services.* Put into a comprehensive framework of reform that also contains an effective gatekeeping function and standards for care, an improved financing framework has the potential to improve the social care and service system.

What kinds of financing frameworks are used for social care? Three models can be considered – two extremes and a middle ground.

- *No public role.* This occurs when there is no public involvement in the financing of social care services (which usually means no public provision either). This solution has the advantage of consumer choice, but complete private finance and provision results in an under-consumption of social services as well as a lower outcomes because: (a) those most in need would not be able to afford the services, and (b) households and individuals in many cases do not have the information to match services with needs, or they may have a conflict of interest (in the case of a child in need of protection from domestic violence, for example).

- *Public finance through provision.* The purely public solution – public finance through government provision -- is the simplest way to ensure that affordable services are provided to populations in need. The problem with this method is that available resources are allocated not among people in need, but among providers. There is no balancing of supply with need or demand, there is just supply, without

choice. The input determines the output and the outcome. There may be an oversupply or undersupply of services relative to demand. Quality problems may also arise since the public sector tends to face problems in sanctioning itself for poor quality, and there are usually limited channels for community and client participation in quality assurance. In its most extreme form, the pure public model substitutes the public sector for the family.

- ***Public finance through reimbursement for services - the purchaser-provider approach.*** This model attempts to duplicate the roles of the consumer and the supplier in the market system, but without the market failures caused by inadequate financing and imperfect information. The public sector retains the financing role, but public sector finance is provided in a more competitive environment, with more voice for the consumer. The public roles described in the above model are divided into two different functions: (a) the purchaser, who finances and purchases care, and (b) the provider, who operates the service delivery units. The job of the purchaser is: (a) to act as gatekeeper or rationer of public funds, determining eligibility, and (b) in the case of more specialized services, to act as the agent for the principal (the vulnerable individual). The purchaser could be any qualified official given responsibility for this task – a teacher, social worker, a child protection officer, a court, etc. Fundamentally, the role of the purchaser is to act as an agent for the financier and the client, to ensure that funds are used to get the best outcome for the client. While the provider could be a public agency, in OECD countries, the provider is more likely to be a private[2] or NGO provider contracted by the public authority, an approach adopted to bring increased client responsiveness and efficiency. In transition countries, public providers are more likely in the initial stages as the private sector is underdeveloped. The private sector will grow over time.

What are the keys to success for a purchaser-provider system? Experience in OECD and developing countries has shown that purchaser provider systems can contribute to higher client satisfaction and cost-efficiency in service delivery if the following are in place.

- The price the purchaser faces reflects the opportunity cost (true price) of supplying the service, rather than a subsidized or distorted price.
- The purchaser is responsible for the financial consequences of proscribing a service for the client, and is the budget holder for social care services for the population in the catchment area.
- Private providers are allowed to enter the market and compete for public funds under appropriate licensing arrangements, with transparent standards and effective quality monitoring arrangements.
- Purchasers assure market stability and avoid over capacity through multi-year sector planning, block contracts, and multi-year contracts. Market exit also has to be managed to ensure continuity of care.

What problems have emerged with purchaser-provider systems? While recognized as an improvement, these models have not solved all the problems of equitable and efficient social service provision. The job of the purchaser is complex, including both gatekeeping and acting on behalf of individuals and families. The purchaser is also balancing access and quality. Clear legislative intent on how to handle these conflicting interests is helpful, as well as a strong role for client monitoring.

Problems have emerged in the contracting side. Public sector suppliers find it difficult to respond to the new incentives, and seek subsidies or ways around the competitive process. Price setting – a negotiation – is not simple since cases are often not standard. Setting prices and writing contracts requires full cost accounting systems on the provider side, as well as good accounting and case management on the purchaser side. As a result,

[2] In this paper, we use the "private" to encompass any non-publicly owned supplier. This includes, for example, foster care or guardianship (a self-employed private provider of parenting services) as well as a private tutor, or a private care giver, or a even a private transportation company. It also includes an NGO such as a charitable foundation or a self-help association.

introducing a purchaser can increase the management and administrative workload. Finally, it may take some efforts by government to develop the market to avoid the situation of only one bidder.

What happens with political and fiscal decentralization? The purchaser-provider framework is well suited to a decentralized government structure, if the roles are assigned properly, and financing flows support the purchaser-provider incentive structure.

- The purchasing level needs adequate financing, and full control of the budget.
- Roles which have large economies of scale, such as quality monitoring and facilities planning and management, should be placed on a high level of government (normally the national level).

How to set eligibility criteria and budgets for care? Once the institutional set-up is in place, public financing policy has to resolve the questions of: (a) how much financing should be provided, and (b) to which services should it be allocated? This is the authorizing legal framework which guides the purchaser. A number of criteria are used in different countries, and each has its drawbacks.

How much public finance should be in place, and should the allocation differ among households? There are strong arguments for providing less than 100% public finance for care, especially for upper income households, as it reduces over-usage and allows more families to be reached. This approach will not work, however, in the face of catastrophic costs or poorly functioning families unwilling to pay, and when prevention is needed. The total cost to the household (including the time of household members) needs to be considered in setting fees and proposing care plans.

How to chose the essential service basket? In principle, the policy framework should encourage the most cost-effective care to be selected. This is a two-dimensional process. Professional judgments and best practice identify the care package that is likely to give the best outcomes. But making choices among needs is by necessity a political decision. It can be facilitated by needs mapping and good outcome monitoring.

Overview of social care provision in Eastern and Central Europe and the Former Soviet Union

The legacy from the planned economy and Soviet era was to provide care for vulnerable citizens in residential institutions. Today, most transition countries still use this approach. Spurred in part by increased poverty and vulnerability during the transition, the rate of institutionalization has grown in almost all countries. Use of community care is growing as well, as countries, mostly with foreign assistance, implement projects aimed at replacing residential care – or parts of it – with community based non-residential alternatives. Unit costs for residential care appear to be 3-4 times as much, *indicating a vast misuse of funds in the current system.*

The incentives for use of residential care are clear. The public monopoly provider model is the dominant one in the Eastern and Central Europe and Central Asian (ECA) region, even after political and fiscal decentralization. As a result, the system is supply driven. Municipalities consider referral to state paid residential care as free facilities. Needs assessments are rarely performed – clients are simply assigned to care on the basis of *ad hoc* priorities (usually by well-meaning local officials). Residential institutions are financed on an input budget. Often, countries do not know the true cost of care since financial statistics do not show the full financial cost. There is no purchasing function, little care planning, and weak outcome monitoring.

IMPLEMENTING A BETTER FRAMEWORK

Improvement in social care requires changes in the financing framework, (complemented by changes in the systems for gatekeeping and standards). This does not mean reducing the public's responsibility for vulnerable citizens. Four main changes have to be made.

- Purchasing: A purchasing organization should be set up with the following tasks: (a) to assess people's needs and to find the appropriate care and service for them, (b) work out a care plan, (c) manage the budget for the care it purchases, rationing care according to policy guidelines, (d) monitor outcomes, and (e) follow the care market, knowing best practice.
- Budget reforms: A new budgeting system needs to be put in place which places all the public funds for social care in the hands of the purchaser, and allows for output-based reimbursements. It should also provide adequate funds for the purchasing function.
- Market-making reforms: Prices to providers have to be based on full opportunity costs, which are explicit and transparent. Public and private providers (current and potential) should submit to licensing. Contracts between purchasers and providers need to be developed which regulate the what should be achieved at what cost. These contract forms should be included in tender documents.
- Provider market reforms: The legal status of existing public institutions, as well as the ownership, may have to be changed to allow them to participate in a tender (and possibly lose). The number of places in residential care will need to contract, and the community care places need to expand. The provider sector needs to be made open to NGOs.

How should the transition be handled? Making the transition to a new financing system will be demanding for all stakeholders. A number of transition problems emerge. Countries seeking to change the financing structure to a purchaser-provider model need to develop a sound project plan. The plan needs to be based on:

- an analysis of the current situation, which maps out what the economic roles are in the current system, the costs and who pays those costs;
- a proposed institutional structure for new system, specifying new roles, responsibilities, accountabilities and financial flows, and an analysis of the incentives;
- a needs assessment, projecting possible future demand scenarios with a change in practices towards more community and family centered care;
- a costing of the demand scenarios;
- a proposed new financial flow structure given (b) and (d);
- a facilities management plan; and
- and activity plan for project implementation.

Changing the financial rules of the game is not enough to ensure better use of public and private resources toward better outcomes. Much more is needed. These issues are dealt with in other papers in this series, and should be part of the overall reform strategy.

What will the transition cost? The analysis described above should help to answer this question. The type of reform program discussed here is not likely to be expenditure reducing, both because: (a) new investments will be needed to develop new services and (b) the increased availability of community-based services will reveal unmet needs, increasing demand for those services. An atmosphere of fiscal crisis is probably counterproductive for this type of reform. It is difficult to reach agreement among stakeholders on new roles and responsibilities as budgets are being sliced. It is better to develop the reform plan in line with available financing. Public demand for social care rises with national income (all other variables constant) so it is reasonable to expect that as income rises,

social care will absorb a constant or growing share of expenditures. Reform is, therefore, important, as it makes it possible to serve more clients with better quality care and reduce the harm done by residential care.

Is this much change possible? Managers and political leaderships work for change once they understand that better methods and tools exist. Frequent international contacts have fostered this awareness and develop a motivation. Many of the features in the new financing structure are in fact already in place or underway. Nevertheless, a reform of this type is a medium term one, and as with any change project, the time frame has to be realistic, and coordinated with the ability of the system to change. It must also be put into a larger framework including gatekeeping functions and appropriate standards for care delivery.

REDIRECTING RESOURCES TO COMMUNITY BASED SERVICES: A CONCEPT PAPER

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INTRODUCTION

One of the legacies of the command economy in Central and Eastern Europe and the former Soviet Union (in World Bank terminology, the Europe and Central Asia or ECA region) is the development of a social protection system for vulnerable individuals focused on institutional care. Universal social protection was provided to families in the form of a guaranteed job and old-age pension, as well as child allowances and benefits in kind such as housing, education, and health care. If an individual needed help beyond this level of universal support, and an institutional place was available, this is what was offered to the family -- to children and adults. Families, in turn were encouraged to use institutional care, instead of trying to keep the family member in the community and participating in school, work, or leisure, alongside others.

It has been well established that the approach of removing a child or an adult from the family and the community is more expensive per client served than more inclusive approaches which are designed to support individuals within their own families and mainstreaming them as much as possible (Tobis, 2000). Countries seeking to change the model of social care services have faced a number of constraints. An important one is how to finance new services. Individuals or their families usually can not finance the costs of these services. How can countries change the financing flows to support a menu of new options, better tailored to the needs of individuals and without putting the burden of financing on the vulnerable people?

Reform of the social protection system in formerly planned economies is taking place within the context of a number of social and economic changes, including fiscal and political decentralization. Ideally, this decentralization offers a good context for reform, as it can provide communities with the resources and responsibilities to ensure that quality services are available to meet their needs. In practice, it has been a challenge, since implementation has not always had this effect. Often, facilities are decentralized rather than resources, and a market for services does not exist. Local governments end up using the institution they are responsible for rather than empowering families to solve the problems using new approaches and tools. The more money that goes to the institution, the less money is available for providing other services or serving more people. Meeting community needs requires breaking this cycle.

The objective of this paper is to provide a framework to help countries re-orient their financing systems for social care, so that they can implement a change program for the social care system. The ultimate objective is that countries use less institutional care and more family-based and inclusive care programs. The latter programs are generally more effective in meeting social needs and, at least on a unit cost basis, less expensive.

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[1] This paper has been prepared as part of a joint UNICEF-World Bank project, "Changing Minds, Policies and Lives", a program designed to support national programs to reduce the institutionalization of vulnerable individuals in Eastern and Central Europe and Central Asia. For further information about this regional project, see http:// eurochild.gla.ac.uk/changing. The authors are grateful for the extensive comments of Gaspar Fajth, Judith Harwin, Loraine Hawkins and, as well as from project team members. Comments to the authors are welcome at lfox@worldbank.org (Fox) or ragnar.gotestam@chello.se (Götestam)

This paper is about the theory and practice of changing the financing flows away from institutions to support reform of social care systems. Taking the age-old advice, "follow the money", we start by reviewing what a good financing policy should do. We consider three concepts: (a) need for services, (b) demand for services, and (c) supply of services. We note that a public role is needed in the first place because those in need often cannot afford to purchase their own services. In addition, clients need specialized help identifying which services would work for them and they need quality assurance.

We look at how a the institutional structure of the public financing framework can use incentives to help balance these three concepts, getting a high overlap so that what is supplied meets the needs which are accepted by the community as appropriate for public finance. We suggest that countries do this by clearly separating the purchase (selection and financing) of care from the provision of care, and we recommend that this institutional approach be used to develop an appropriate role for the private sector.

In section II, we examine what is going on in specific countries. We ask what are the needs for social protection services, what kind of care is currently being supplied in selected countries in the ECA region, what it costs, and who is paying for it. We use the yardstick set out in the first section to evaluate the current situation. How well is the financing framework allocating resources relative to needs and demands? We find that input-based financing is still the main source of financing in most countries, hampering the desired shift in service and product mix.

We then look at what policy measures countries need to undertake to change the financing mix, and what are the problems in realizing this transition.

Changing the financing system is a necessary, but not sufficient condition to achieving the goal of better social care services. A system wide change program is needed. Other components of a change program would include reforms to ensure quality of provision such as standards and accreditation, training, information to clients, monitoring, etc., and those which improve the gatekeeping and needs assessment process, including rigorous outcome and impact evaluation. The effectiveness of the financing framework in doing its job is determined in part by the effectiveness of these other policy tools.[1]

[1] See Harwin and Bilson (2000) and Bilson and Gotestam (2000).

PART I: WHAT SHOULD A SOCIAL CARE SERVICE FINANCING FRAMEWORK DO?

Social care services are services supplied to vulnerable individuals and families to help them out of poverty and exclusion, and live a full and satisfying life. Vulnerable individuals are usually considered to be:

- Children (minors) and adults with serious disabilities (temporary or permanent), including the frail elderly,
- Children (minors) or adults at risk of abuse or deprivation of basic needs, and
- Children (minors) deprived of parental care (usually because of absence, illness including disabling addiction, or death of parents) or at risk of deprivation of parental care.

Social care services are a support for everyday living. They complement support provided by families. They should also be a complement to other social services (health care, education, housing, employment assistance and training, etc.), as well as a support to other public services (justice, etc.). Indeed, encounters with other services often trigger the needs assessment of the client and referral to care services. The objective of social care services may be prevention of the deprivation of human rights or well-being or the correction of the problem.

In some cases, social care services replace other social services. This is especially true of residential care. As a general rule, replacement of other services in a specialized institution is more expensive and leads to poorer outcomes in terms of inclusion, functionality, and well-being.

Families of these vulnerable groups are also at risk. They are at risk primarily because the individual risk factors include poverty or are correlated with poverty, but also because these factors can lead to emotional and social stress within the family[2]. This reduces the ability of the family to support all members. Social services should have the outcome of reducing the stress in the family, as well as supporting the individual.

IDENTIFYING THE PUBLIC SECTOR ROLE IN SOCIAL CARE SERVICE PROVISION

Needs and demand. Historically families have provided most social care services themselves. For example, children helped other children and adults to go about daily living, and adults would take care of a family member not able to work, or give special attention to a child. Extended family networks would help sub-family units in crisis by giving transfers in cash or in kind, and with emotional support. Religious groups and other charities would often provide help as well. Richer families would hire services (for example, a care taker for someone with mobility problems or a teacher for home schooling for a child with special needs).

As the workplace increasingly moved outside the home, formal labor force participation increased, and extended family networks fragmented, the opportunity cost of family labor to take care of members in need grew. In addition, new knowledge and technologies spurred the development of new, professional, and often higher cost services. Families usually do not have the financial resources to buy these services. They often need professional advice on choosing the service package (as with health care).

In principal, social care services could be privately insurable – and in countries with a well developed private insurance sector, some risks are insured for upper income sections of the population (for example, long term nursing care for the elderly). However, there are major problems in developing an insurance market in this sector.[3] First, vulnerability tends to be correlated with poverty, so the demand is greatest among those least able

[2] See for example, UNICEF (1997) on poverty and vulnerability among children at risk, and Elwan, (1999), for a discussion of the links between disability and poverty.

[3] Barr, 2001, develops this argument more fully, esp. in chapter 3.

to afford insurance. Without enforced risk pooling, there is a serious adverse selection[4] problem which would make premiums completely unaffordable.[5] Moral hazard problems (increased consumption of the service in the presence of insurance)[6] is also a problem in the case of social care services. Yet social care services are valuable to families and to society, since society wants to protect and support the vulnerable. As national income increases, the demand for public finance for these services increases (Barr, 2001; Lindert, 1996). Public finance is seen as the best substitute for inefficient and ineffective private markets.

Public finance for social care services immediately creates problems of rationing. Needs of households for free or subsidized services can be considered virtually unlimited. However, financing is not unlimited (public or private). The public sector has to ration the financing available, prioritizing needs and resources so that public financing is directed to ensuring access to services for those with the greatest need, and to those services that produce the best outcomes. If a good rationing system is not in place, those most in need are likely to find themselves without services.

A broad range of services may be provided. Institutional care is only one of the possible products, and it should be used very infrequently. More family-friendly services include day programs, temporary shelters, counseling and family support, transportation services, prosthesis, special health or education services or training, etc. Typically, it is more cost effective to prevent a problem than to correct it, although the boundary between preventive services and corrective services is porous.[7] The cost of these services varies, as does the quality, depending on how production is organized and what technology and methods are used. Some products work well for some needs but not others.

Rationing services and matching them to clients is not a simple problem. It usually requires technical knowledge and training to perform the needs assessment and service matching. In some cases, the family can select and purchase the service and be responsible for monitoring the results, and the role of the government is limited to assisting with financing based on a needs assessment (assessing eligibility). In other cases, the assistance of social worker or other trained specialist is needed to select the service and monitor the result. In the case of children, especially children deprived of parental care, social care almost always requires someone to act on the child's behalf. This person is called an *agent* for the individual or family in need (the principal). The agent acts as one of the gatekeepers to the system, rationing care.[8] All participants in the system need the specialized knowledge of the agent. However, most of the system management problems occur around the conflicting interests of the principal and the financier, as intermediated through the agent.

Supply. Because of the difficulty in ensuring an adequate supply of quality services, in most countries, the public sector plays a major role in organizing the supply of services. This is done by either: (a) directly supplying the service; (b) contracting out the supply of the service to a monopolist private or NGO supplier according to

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[4] Adverse selection occurs when the risks are identifiable in advance, and mainly the highest risk people buy an insurance product. This results in a very high price for the product, and then the insurance becomes unaffordable. The solution is to force everyone (or most people) to buy the product, so that the price is lower and `the risk spread out. Mandatory auto insurance is an example of this type of risk pooling.

[5] See, for example, Aarts and de Jong (1999) for a discussion of which private costs associated with disability are insurable, when, and by whom. Birth-related disabilities are particularly difficult to insure, since the insurance would rarely be purchased voluntarily in advance of the risk. Low probability, high cost events are also hard to get people to purchase insurance for.

[6] Moral hazard is common in personal services. In health care, for example, if going to the clinic is free, people go more often, sometimes even when a visit is not strictly necessary, but because they are lonely or unsure. Co-payments (charging a small fee) are the standard remedy, but these can cause access problems. Over-consumption of medicine when it free is another common moral hazard behavior. Counseling services are also subject to this problem, and the usage needs to be strictly limited.

[7] For example, a class on effective parenting for young mothers and families can be considered preventive or corrective.

[8] See paper Harwin and Bilson, (2002).

service standards; and/or (c) by setting standards for service provision by a competitive private sector (usually, but not exclusively, non-profit). The public sector also helps families to monitor results, and conducts research on techniques and approaches, to encourage the development and supply of new and cost-effective models.

Thus there are three distinct aspects of social care service delivery which have to be balanced:

- the needs of households and vulnerable individuals for assistance or support (the needs of the principal);
- the identification of appropriate and affordable interventions and prioritization of funding to families and individuals for the interventions given costs and effectiveness (demand, often involving an agent who acts on behalf of the principal and a gatekeeper who works on behalf of the financier according to norms and laws); and
- the supply of the services efficiently, at a high quality (providers).

The role of the financing framework is to balance these three aspects. A good financing framework does this by:

- ensuring that demand, as determined by the gatekeeper and the agent or the individual, is financed so that care is rationed properly, according to agreed criteria, so that those most in need receive access to services which have the high benefits, and
- provide incentives so that the providers supply services efficiently and at a high quality.

In other words, one of the key tasks of the financing system is to try to align the incentives of the system participants so that the interests of the individual and society are served efficiently. These interests are often different, as can be seen in Table 1.

The financing framework is therefore one of the key public policy tools to ensure access, cost-effectiveness and quality in the social services. These are the assessment criteria for any framework. As we will see below, the most effective way to do this is to provide a separate channel or voice for the interests of each of the three parties to be articulated, so that they can be balanced. Especially important is the voice of the client, since he/she tends to have the least power in the system yet is most important in solving the problem. Inclusive problem resolution is difficult unless the client agrees with the solution or at least understands it. Other complementary tools to achieve this balance include those which ensure quality of provision such as standards and accreditation, training, information to clients, monitoring, etc., and those which improve the gatekeeping and needs assessment process, including rigorous outcome and impact evaluation. The effectiveness of the financing framework in doing its job is determined in part by the effectiveness of these other policy tools.

FINANCING MODELS

Organizing a financing framework which supports efficient and effective social care provision is primarily about institutional structures. What are the roles and responsibilities of institutions in social care system? If a key role is unfilled - or mixed up with another, so that there is a conflict of interest – fewer people will be served, they will be served less well, and resources are likely to be wasted. Below we discuss several ways this can occur in conventional financing models.

No public role – access and quality failure. This occurs when there is no public financing of social care services, only private financing. In most cases, this would imply no public provision as well. In the absence of public sector involvement, there would be no agent for the principal and no gatekeeper – households would either provide the services themselves (family care) or purchase services from providers just like cars or meals in

restaurants are purchased.[9] This was the case for most countries 100 years ago, and remains the situation today in many of the world's poorest countries. In this case plenty of channels exist for information about demands to providers, and competition could produce a variety of services if households have money to purchase them. But there would be few channels of information about needs, since those in need may not have the funds to channel money into demands. As we noted above, this approach would result in an under-consumption of social services as well as lower outcomes because: (a) those most in need would not be able to afford the services, and (b) households and individuals in many cases do not have the information to match services with needs, or they may have a conflict of interest (in the case of a child in need of protection from domestic violence, for example). Because of a thin market, there could also be an under-supply of services. If there is no quality regulation (for example, certification of providers), high cost, high quality providers might not enter the market since they would have to compete with poor quality but cheaper services. Economists call this type of problem a "market failure". In a market economy, the public sector should try to remedy this failure with public resources to increase consumption, and with regulation to improve quality.

Table 1: Needs, Demand and Supply

	Needs (client)	*Demand (financier)*	*Supply (provider)*
Who observes?	Point of entry person: health worker, teacher, police, social worker, day nursery staff, family. Client can self-identify	Office in charge of supporting families to cope or – if needed - referring individuals to care (the gatekeeper and the agent).	Everyone in the market
How determined?	Revealed by client through needs assessment (review of situation and communication with the individual or family at risk).	Revealed by public and private financiers through the budget allocations- the total envelope available to spend on meeting needs, and - the priority or rationing plan used by the gatekeeper (set in legal norms).	The quantity and quality of services supplied by the providers.
How measured and evaluated?	Outcome measurement – the result for the individual	Budgets and care plan procedures.	Output measurement – the quality-adjusted quantity of services relative to the price
Policy tools	Outreach, targeting	Legislation sets eligibility thresholds, targets, and financing responsibilities; budget sets total financing	Cost accounting, Quality monitoring (standards)

[9]This is a bit of a simplification. Even in pure market system, an agent might still be needed to develop a care plan and make recommendations on services. However, most likely, the supplier would include this in the package, biasing results toward the services provided. In the case of private insurance, a gatekeeper would automatically be present to control moral hazard.

Public financing through direct budget financing of public units – quality failure. In the centrally planned economy, the problem of financing is solved through the government itself delivering a supply of services which are rationed to the population in need by an agent/gatekeeper. Available resources are allocated not among people in need, but among providers. The problem with this approach is that since the agent works for the supplier, there is no independent channel for information about needs or demands. There is no balancing of supply with need or demand, there is just supply, without choice. The input determines the output and the outcome. There may be and oversupply or undersupply or services relative to demand. But this is unknown, since there is no independent voice for demand. There are only needs, and services. The incentives are mostly on the side of the providers. Quality problems may also arise since the public sector tends to face problems in sanctioning itself for poor quality, and there are usually limited channels for community and client participation in quality assurance, through choice and independent feedback. In its most extreme form, the pure public model substitutes the public sector for the family.

The purely public solution is, however, the simplest way to ensure that services are provided to populations in need. All market economies have used this approach at some point to ensure social sector service supply meets demand, including health, education and social care services. This approach has come under criticism (see Torres and Mathur, 1995; OECD, 1997; Preker, Harding, Girishankar, 1999, and the references therein). In addition to the problems above, it may not produce the best services most efficiently, since the monopolist faces no pressures from other competitors. Public service "culture" is often not client oriented. Dissatisfaction with public sector provision has been termed "public sector failure". Countries have been seeking a way out of the bind between public monopoly with public sector failure and no public financing or provision with private market failure.

Public financing through reimbursement for services - purchaser-provider models. The result of this searching has been the evolution of the "purchaser-provider" model. This model uses the natural quality improvement mechanism which arises from the tension between the roles of the consumer and the supplier in a market system, but without the access failure resulting from only private financing. It starts by recognizing that the public intervention should be to fix the problems on the demand side – inadequate financing and information in families. These problems can be corrected through public financing, agency, and quality monitoring. In the simplest case the public sector may still be responsible for the same roles as in the public provision model. However, these roles are separated into two different functions performed by two different agencies: (a) the purchaser, who finances and purchases care, and (b) the provider, who operates the service delivery units. The job of the purchaser is: (a) to act as gatekeeper or rationer of public funds, determining eligibility, and (b) in the case of more specialized services, to act as the agent for the principal (the vulnerable individual). The purchaser uses public financing (or a mix of public and private financing) to purchase services from suppliers for individuals. The purchaser could be any qualified official given responsibility for this task – a teacher, social worker, a child protection officer, a court, etc. Fundamentally, the role of the purchaser is to act as an agent for the financier and the client, to ensure that funds are used to get the best outcome for the client. This implies seeking the highest value for money, and ensuring as much access as the financial envelope affords. The purchaser-provider approach is also know as "money follows the client" (as opposed to the money following the supplier).

While the provider could be a public agency, in OECD countries, the provider is more likely to be a private[1] or NGO provider contracted by the public authority, an approach adopted to bring increased client responsiveness and efficiency.[2] One of the strengths of the purchaser-provider model is that it allows a market for providers to emerge, gaining the benefits from competition. In a full purchaser-provider system, multiple private

[1] In this paper, we use the "private" to encompass any non-publicly owned supplier. This includes, for example, foster care or guardianship (a self-employed private provider of parenting services) as well as a private tutor, or a private care giver, or a even a private transportation company. It also includes an NGO such as a charitable foundation or a self-help association.
[2] But if the private supplier is still the only provider, contracting out still lacks the feature of consumer choice.

providers supply care to clients, allowing a full articulation of client need within the financing framework. The public sector role is to provide and ration the financing (in other words, to universally insure the population).

The public sector still maintains the role of quality assurance. This role is exercised both through standard setting and licensing, and through monitoring of standards and outcomes. Client groups can be tasked to assist in the monitoring, as can self-regulating organizations such as professional bodies. The public sector can also educate clients as consumers, in some cases reducing the role of the purchaser to needs assessment and financing channel, while the client selects and evaluates the provider.[3]
Purchaser-provider models have a number of advantages. First, they allow a clearer transmission of demand signals to the provider, which can improve efficiency on the supply side. Second, they allow the separation of needs assessment and financing from provision, giving voice and power to this process, independent from the problem of service provision. Third, they give an explicit role to the care management process, allowing the quality of this function to improve. Finally, they allow the emergence of competition and a market in the service supply sector, which should improve quality. They allow the public sector to concentrate on what are clearly monopoly public functions – quality regulation and insuring risk in the face of an insurance market failure – and the private sector to produce the services for individuals (within the constraint of public quality regulation – see Bilson and Götestam, (2002) for a discussion).

MAKING THE MARKET WORK

Pricing and budgeting are keys to effective purchasing. This means, first and foremost, that the pricing structure the purchaser faces must reflect the opportunity cost[4] of supplying the services. The price the purchaser pays to the supplier must be a fair one, at least the average cost of supplying the service over the medium term, including maintaining capital, service improvements, etc. If the price is below this cost, the supplier will go out of business or service levels will decline.[5]

The second key is that "the one who decides, pays". This means the that purchasing organization must be responsible for the financial consequences of demanding a service for the client. The purchaser must therefore control the whole public (or privately insured) social care budget for a given population, and be accountable for all access issues, as well as the cost-effectiveness of service decisions.

The third key is that the budget must flow through a "single pipe" to the purchaser. This means that the funds available to the purchaser must all come through one channel – the single pipe. In other words, the social worker purchasing services should not be biased by whether the funds come from one budget or another. No monies can flow to the providers directly, as this would impede clear price signals and prevent the purchaser from seeking the most cost-effective solution. Monies flowing directly to a provider usually results in a subsidy to a provider, distorting the price structure. User fees or co-payments must also be consistent across substitutable services.[6]

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[3] The "voucher" or insurance model, with client choice, works best in cases where the diagnosis of the problem is relatively straight-forward and the outcome is easily observed such as mobility services or home care for the elderly or disabled. Where the outcome is more difficult to observe or the supplier can induce increased demand, a more extensive involvement of the purchaser is needed, raising more principal-agent problems.

[4] Resources are never free. Opportunity cost is the cost of the alternate use. Opportunity cost may not be monetary, and may not be observed in the market, but it always exists. For example, public buildings used to supply residential services could also be used as schools, police stations, or sold and the money used to help poor children.

[5] This does that mean that the supplier should get whatever price they propose. It simply means that the prices the purchaser faces should not be subsidized (by the public sector, for example, in the form of free capital, or by the private sector in the form of underpricing).

[6] For example, if the budget pays 100% of service cost for a public provider but only 75% for a private provider, the purchaser's decision is distorted. Likewise, if the family has to pay 10% of the cost for home care, but pays nothing for institutional care, the family may push the purchaser to choose residential care.

If these rules are in place, the purchaser (for example, a social worker) can theoretically get the most cost-effective allocation among all possible services for the client, and use the budget to meet the highest priority needs. If, however, there is market or budget segmentation, these optimizations will not take place.

While recognized as an improvement, purchaser-provider approaches have not solved all the problems of public service provision, and have created new problems. First, there is still the problem of needs assessment and allocation inherent in the principle/agent problem. If someone makes the decisions on service purchase other than the person in need (that is, the client or the principal), what mechanisms are in place to assure that the client's needs are met as far as possible given limited financing? In other words, how to be sure that the agent (with their own interests) acts properly with respect to the principal in a complex situation? One method of reducing this problem is to reduce the role of the agent to a minimum, and empower the client as much as possible A market for providers within a range of standardized services can reduce the danger of misallocation by the purchaser, especially if the choice of provider for the standardized service is left to clients. Empowering clients also helps to ensure better outcomes, since the client is included in the treatment decisions. The danger is, however, that full public financing combined with weak agency may increase moral hazard (raising the cost).

Allowing choice is not always possible, in the case of children, for example, or where there is a conflict of interests in the household. In some cases, assessment of needs and results is difficult, and the client will perhaps make a short term, easy choice, or one without long term benefits. Effective outcome monitoring is needed which tracks the results of case management decisions.[7] It is important that the agency in charge of monitoring not be the purchaser. Consumer/family roles in monitoring especially through advocacy organizations, can be a safeguard to balance the purchaser's power.

The second issue is how to make sure that the purchaser rations care effectively, using limited funds. In other words, how to make sure that the policy intent in the law is followed with respect to the most needy and the most at risk? The purchaser is implicitly balancing access and quality within a fixed budget, often in a non-transparent manner. This issue is also best addressed through community level monitoring and feedback. At the national level, community demographics compared with service utilization can also provide information about how well the purchasing function is being performed.

Problems have emerged with respect to the provider market. When purchaser/provider models are put in place, provision is usually in the hands of the public sector. Public sector agencies are not always able or willing to respond flexibly to new demands. Private providers may enter the market, but if the public sector does not shrink in response there will be an oversupply in the public sector, which will push up unit costs and/or lead to deficits in agency budgets. This is because empty places have to be paid and the provider will add the cost for these empty places to the bed-day price. In the face of these deficits, purchasers will face pressures to use public services over private ones. Experience has proved that the public sector providers can use political power to undermine competition or downsizing. This issue requires careful attention. Exit and transition strategies have to be formulated in advance to ensure continuity of care.

Market stability is also a key issue. Investment is required by private or public providers to develop care programs. Providers will only undertake this investment if they are assured of a client base. Clients also need continuity, especially in the case of long term care. Countries have developed various methods to resolve this problem, including multi-year contracts, block contracts, etc. (See box on Stockholm, below)

Setting prices has also been a problem. This is usually a negotiation between purchasers and providers. For the supplier, the price has to equal the long run average cost in order to maintain assets and stay in business.

[7] For a discussion of outcome monitoring see Bilson and Götestam, (2002). It is particularly difficult in the case of social care services, since results are usually not directly observed, but instead inferred from individual behavior.

Analyzing this requires a full cost accounting. The purchaser is seeking the lowest price possible in order to maximize value. Price stability is needed in both markets for the necessary investments to take place.

Prices are usually set for an "average" case. But individuals differ, and it is not easy to predict needs. These vary enormously and therefore also the costs to meet these needs. A care facility that only attends to clients with limited needs will have less expenditures (and therefore lower prices) than a care facility that takes on demanding cases that need constant attention from staff and expertise. In a growing market it is easier to find care options for mildly disabled clients than for severely disabled ones, for example. A mildly disabled client is able to participate in the care, make own efforts and contribute to his own rehabilitation, which eases the burden on the staff and the costs.

Thus there is a limit to the concept of cost-effective purchasing. Best practice experiences are that one cannot really rehabilitate a client, just facilitate the client to rehabilitate himself by providing the supportive conditions.

It should be noted that purchaser-provider models are more expensive administratively than public monopoly models, especially in the case of multiple providers. Does this raise the total cost of social care services, reducing access? Not necessarily. Some of these costs will be offset by gains in efficiency stemming from competition. In the U.K., the introduction of competition during the 1990s resulted in increased productivity and lower costs, especially when public entities are submitted to competition (Fölster, 1993). Some of the additional costs observed with the introduction of purchasing are for functions which need to be performed to increase the value of care (improve outcomes), such as better needs assessment and agency on the part of the public financier, and better quality regulation. Often the budget of a public system in the case of a public monopoly does not reflect the full cost of the system (e.g. capital charges and maintenance). However, it should be recognized that inserting a purchaser-provider model in a situation of continued monopoly will have limited efficiency gains compared with the benefits of competition on the provider side.

To summarize, vulnerable individuals need social care services, and societies want them to have these services at an affordable level. Governments have to play a role in assuring that these services are available to those who need them at the required quality level. This means governments have to:

- finance some or all of the costs for some or all or the clients groups,
- decide who should receive what services with limited public money, based on good tools for needs assessment, careful evaluation of results for all clients, and policies on targeting which ensure value for money in terms of social goals such as preventing deprivation or human rights violations and fostering inclusion; and
- monitor quality for all services provided (public and private).

Government can do this through direct service provision. However, to encourage a more efficient, flexible, and diverse provider network, governments in OECD countries have been introducing purchaser/provider financing models.

Box 1: Contracting out Residential Care for Children in Iceland

In the early 1990s, the Government of Iceland was concerned about the cost of residential care for children in government - owned and operated facilities. Costs seemed to rising without a comparable increase in services or quality. As part of the Government's Competitive Tendering Initiative, it was decided in 1993 to experiment with contracting out management services for a new residential care home. After much discussion on qualifications and standards, a tender was launched. Potential contractors were identified through advertising, they were ranked according to their qualifications, and a contract was signed with the leading candidate following negotiations.

The experiment was judged a success, and as a result, in 1995, a purchasing agency was created – the national Child Protection Agency. Today, most residential treatment homes for children have been contracted out or are being contracted out. Whenever possible, former management is invited to bid. This preserves expertise and contributes to stability of service. Contracts are usually for two years with an extension clause.

A recent evaluation highlighted the following benefits of the new system:

- contracting out has added flexibility to the system, making it more client responsive;
- unit costs have declined 20%, government overhead costs have also declined, and budget overruns have been eliminated; and
- quality standards are higher owing to the requirement for the buyer to define requirements and expectations and the separation of service from supervision.

Source: OECD, (1997)

DECENTRALIZATION

Thus far, "government" or "public" has been considered as one unitary entity. In all but the smallest countries of the world, however, there are multiple levels of government. Political and fiscal decentralization has been an important trend in the last 30 years. The goals have been multiple, but they are primarily clustered around ensuring more community voice and participation. This is believed to produce better public service through more transparency and accountability, as well as flexibility to adjust to service needs.

In theory, the purchaser-provider model is well suited to a decentralized framework. This is because local governments often are even less able to be effective monopoly suppliers of services than national ones. In addition, the case of some services, there may be economies in the provision of care services beyond the catchment area of the local government, implying that it is inefficient for local governments to supply the services directly. Local governments may lack the long term financing necessary to invest in care provision. But local governments can be effective purchasers, as they can identify the needs of their populations, prioritize them and purchase care for them, *assuming the local governments have an adequate financing base, either from own revenues or central government transfers*. Once again, the key role of the financing framework emerges. For a small municipality, getting rid of the burden of managing an institution means that the municipality can concentrate on its role as a good purchaser.

There can be many obstacles to implementing a purchaser-provider system for social care. The first is the one alluded to above: the lack of resources at the local level for social care purchasing. This can occur for several reasons.

- local governments have been given too many functions, relative to their share of total public resources (the overall pot of resources is too small),
- some local governments have more vulnerable individuals than others but they have fewer resources (the risk pool is too small and/or the mechanisms for horizontal equity are not in place), or

- local governments do not allocate enough funds to meet social care needs.[8]

Solutions to these problems require central government intervention. The first two can be addressed with increased untargeted transfers to local governments. The last one requires national standards or norms to ensure that a minimum standard of social care services is available nationwide. It may also require earmarked transfers to some local governments.

A second reason why decentralization does not result in the emergence of the purchaser provider model is that local governments are not able or allowed to optimize their social care purchasing (a set of providers and a payment mechanism does not emerge). There are several reasons why this can emerge.

- *Local ownership of facilities*: in some countries, the decentralization actually implemented was a decentralization of facilities, not functions. This means, for example, that the local government did not get revenues, but a large care home. Transfers from central government may even by tied to the operation of this home. Until the local government can get rid of this dinosaur, (by selling or transferring it to an NGO, closing down parts, or closing the whole thing) the government is in the situation of the monopoly supplier of care and there is nothing to purchase.
- *No payment system*: a functioning system of payments between purchasers and providers is necessary. During the first years of decentralization, (when many of the suppliers are still government owned) this may not be in place.
- *Skill shortages*: local governments may lack the skills to purchase care effectively and to monitor outcomes.

These problems can be mitigated through actions of the central government or an association of local governments. (See the box on Stockholm for an example of local governments pooling their resources to solve these problems). For example, as a service to purchasers and clients, one national agency can be entrusted with standard setting and quality monitoring. A national agency can also provide methodological support to gatekeepers and providers, and support research and training on best practice. The national government can help to support an intergovernmental payment system, with serious sanctions for non-payers. The restructuring of the provider sector can be assisted by national governments as well, through master planning processes and one-time subsidies to help restructure/close institutions.

One problem which can not be resolved is when municipalities are too small to manage low probability/high cost social risks. This can happen for example, when the main employer in a town shuts down, causing extensive social stress and no public revenue. It can also happen with very small municipalities. In this case, decentralization of the social care responsibility is not practical without some consolidation of government units of development of a regional government structure.

In sum, political and fiscal decentralization can provide support for the development of an improved financing framework. But for this to happen, partnership and support from the central government is usually necessary to ensure the transformation of the monopoly suppliers to providers in a properly regulated quasi-market.

[8] This statement obviously begs the question of "how much social care is enough and who should decide"? This is an important question beyond the scope of this paper. For a discussion of that question in the OECD context see Lindert, (1996); in a developing country context, see Klugman, (1997).

HOW MUCH CARE SHOULD BE FINANCED BY THE PUBLIC SECTOR, AND FOR WHOM? HOW SHOULD THE BUDGET BE SPENT?

As we have discussed above, public sector financing effectively combines two roles:

- selection of care (the expert or the agent function), and
- public subsidy to help reduce the costs of care for families.

It is important to remember that the just because the first role is needed does not mean the second one is needed. If care is not very expensive, families could pay the cost themselves, with the public role limited to the agency function and quality monitoring. But, as noted above, care is often expensive for families, (residential care being prohibitively expensive), so public subsidies end up being put in place to reduce the cost.

Ideally, the selection of care by the agent and the decision on amount of subsidy should be separate decisions. The agent should make a "technocratic" recommendation, based on the latest evidence on what program would be best for a client's needs. In reality, this is not possible. Limited budgets, the difficulty of determining effectiveness of services and the political and social context all combine to mingle the decisions together. The purchaser is making both decisions simultaneously. The means to pay for the care always enters into the decision on the how much care and what type to provide. It can not be fully independent.

The question still remains of how much subsidy should be in place, and to whom it should be given. The mere fact of a need does not justify 100% public sector financing. Resources, especially public ones, are always limited, and face competing priorities, equally important to someone's well being (i.e. education, health care, roads, etc.). Taxes cost money to collect, and the higher they are, the more evasion there is, so the higher the cost to the economy of collecting taxes and providing public services. Needs, on the other hand, are infinite. As a result, the funds available to the purchaser will always be too little. Choices among needs and interventions are a daily problem in setting and implementing social policy. Rationing is a reality.

Choosing among households. In considering how to ration funds, most economists argue that public subsidies should not go to those who could pay for the care themselves (the targeting or equity approach). A corollary to this argument is the recommendation to require some contribution to service cost from almost everyone (a co-payment). The co-payment is supposed to provide a signal to the purchaser about the client's valuation of the service, and reduce the increase in consumption which always occurs when something is free. This economic argument calls for: (a) directing subsidies to the poor to avoid wasting resources, and (b) some form of user fees.[9]

There are problems in applying this approach. First, ability to pay is sometimes difficult to measure – how to compare rural with urban, and children's needs with adults needs? Poverty can be transitory, with those in need of social care services in transitory poverty. Forcing them to pay could reduce their ability to get out of poverty. But once they are out of poverty, it is hard to force a direct contribution, but easy to collect taxes from them. Second, some problems are catastrophic in nature – the expenditure is large at a given point in time (or over time), so that having to pay out of pocket for it would push the non-poor into poverty. Examples of catastrophic problems include a temporarily or permanently disabled individual in the family, the onset of HIV/AIDS, etc. From this point of view, public subsidies are a form of insurance in an insurance market failure. Everyone pays taxes and everyone is insured. There should be no discrimination among individuals with respect to access.[10] It should be noted that this philosophy does not solve the rationing problem – it simply adds another dimension and may affect the size of the service package.

[9] Note that the rules for requiring co-payments should be specified in advance, not decided ad hoc by the purchaser.
[10] This approach is referred to as the "solidarity" principle.

In assessing ability to pay, it is important to look at total costs of the service to the household. Even if the service is free, there may be travel time and the time of other household members. If these costs are not considered, a 'free' service might end up being expensive, and therefore under-used. For example, once a client has been referred to residential care the economic responsibilities of his/her family and breadwinner appears to be taken over by the residential institution. Residential care appears to replace the family, rather than being complementary. Non-residential care involves families to clients to a larger extent. Open care requires a family; someone who can take the child to the premises where the open care is provided. Halfway care facilities could not be operating unless there is someone to attend to the other half; to assist the client between his/her visits to the halfway house.

If the care approach is exclusive (as most residential institutions are) most costs stay on the caregiver. But if we want the care to be inclusive (to encourage clients to get back to society and family) we will be depending on participation and contribution from that part of society. Care cannot be inclusive unless there is someone outside the institution to care, show concern and compassion. Usually, these costs are not significant and most families will be prepared to sacrifice a little of its own comfort and economy to help a child or a frail elderly parent. In some cases it is likely that the government will have to assist the family with cash benefits to allow for desired participation in the care process.

Finally, ability to pay and willingness to pay are different. Some services are too important to society (e.g. child protection) and they can not be left entirely up to the family's willingness to pay even a part of the cost. Public financing is required. In some cases, public financing may be combined with legal requirements for the household to pay part of the cost.

Choosing among services: the essential service basket. Some argue that subsidies should be provided according to the type of services – which have the greatest impact on the most people for the smallest amount of money? Which services are 'basic rights'? For example, effective prevention lowers the overall cost of social care services, so this type of service should be subsidized. It is true that preventive services are difficult to target and the argument for a public subsidy is greatest here, since these services can be consumed by a number of households at the same time with the benefits spread across the population in terms of lower overall social care costs for the same result. The problem with this approach is that separating out prevention, cure and maintenance is complex in social care. It also implies very complex value judgments among people. Why is the need of a child with a mild disability greater than that of an elderly home-bound person? How much greater is it? Most societies are not prepared to face these choices explicitly.

In practice, countries tend to use combinations of the criteria in Table 2, depending on social tradition, degree of homogeneity, income level, etc. The mix of criteria will be reflected in the financing rules given to the purchaser. Current ideas about good practice (recognizing the political and social arena in which these choices are made) include the following:

- *Needs mapping.* Purchasers should prepare a community needs mapping and try to identify those at highest risk. They should consult with the community to determine local priorities. Purchases should be partly planned in advance. Planning should try to define a basic package that best suits the communities needs and available financing.
- *Price conscious care planning.* Financing should include both low-cost day services and high-cost residential interventions to avoid the low cost ones being rejected by households with limited means in favor of the subsidized high cost ones. For a given problem, purchasers should use the lower cost ones as much as possible and the higher-cost ones as little as possible. This tends to favor day care services, which on average tend to have better outcomes.

Table 2: 'Objective' Criteria for Allocating Funds Among Families and Programs

Criteria	Who benefits?
Equity – finance care for the poorest, others pay on a sliding scale.	This criterion seems to be objective, until the question of how to define poverty and available resources is faced (including resources at the time of a catastrophe). In practice this criterion tends favors whichever group is judged to be in need (the poor, minority groups, women, age groups, etc.).
Solidarity – everyone has equal access if they have need.	This criterion usually results in an assured basic package, but may result in under-funding of services to the poorest owing to a budget constraint, while substituting for the family in some cases.
Catastrophic cost – finance care with a cost much too high for an individual family to bear (the social insurance approach).	This criterion favors severe problems over smaller, more manageable ones. It also does not favor prevention, which may mean that small problems grow into big ones.
Cost effectiveness– finance care with the biggest impact on someone's life.	This criterion also seems to be objective, but actually favors those with the least severe problems, since these are easier and the service has a much higher chance of succeeding. It also favors prevention. It should be noted that "effectiveness" is exceedingly difficult to measure, and is not the same as success. Cost effectiveness should be applied to treatments which provide similar outcomes, but not to ration funds between treatments with different outcomes.

- *User fees.* Wherever possible, seek a contribution from the household. This contribution will both save money and provide information about the client's perception of effectiveness. For example, the elderly will chose home care three times a week instead of once a week if the care is free. But if the client pays a fee per visit, then three times a week care will only be selected if it is really needed. Equally, co-payments for homecare should not be higher than for residential care. If they are, the family will wrongly pressure the system for residential care. User fees should be similar for substitutable services (those addressing the same problem).
- Purchasers should consider total costs to the household of service options, and include those in evaluating household contribution.
- *Choice.* Provide choice to client, with prices which reflect the opportunity cost. Options with a higher cost will only be chosen when the benefits are perceived to be higher.
- *Information.* Allocate financing to monitoring and evaluation. This should include analyzing household costs and perceptions of value. It should also include educating clients and the community about needs, options and choices, to reduce the information gap between the community and the purchaser.

In sum, OECD countries have more or less abandoned the idea that the public authorities shall both finance social assistance services and provide (produce and deliver) the services through their own organizations. A change can be seen towards a system by which public authorities (state, counties, municipalities) take the responsibility for the financing and purchasing while the provision (production and delivery) of the services is entrusted to others. In the provision sector, monopolistic public provision of social care services is unlikely to produce the best results for society or the client. Some kind of
market provision offers much better options in terms of quality. However, even in areas where no private suppliers are ready to provide the services, the public authorities have made a division between the purchaser and the provider's role but kept them both within the framework of the public authority. Development of a purchaser-provider financing framework is critical to establishing this market, and ensuring access.

However, the purchaser role is a complex one, subject to a number of political, social and economic pressures. The purchaser serves multiple interests. The rationing of funds among service products and clients is the result of the interplay of these interests through the institution of the purchaser.

Information transmission is the key to making the system work. The easiest information to transmit is the cost of service, which comes through the price

signals. The market helps to transmit information about production efficiency. However, as each client is different and therefore services are not standardized, the information in a price signal is less than would be expected in another type of service industry.

More complex are the need and outcome signals. Demand (what society is willing to pay with private and public funds) emerges through a political and technical process. Services free to client will always find more needs than services that are costly to the client. However, clients understand quality, and given an opportunity will give the purchaser/financier information about perceived quality and effectiveness.

Fiscal and political decentralization may make the balancing of these interests even more difficult. However, it may also provide the political opportunity for the introduction of a purchaser/provider model.

Box 2: Purchasing and providing social care for adolescents and children in Stockholm city

The approach of municipality of Stockholm (pop. 750 000) to ensuring the availability of social care services for adolescents and children at risk provides an example of how the purchaser-provider spilt works in practice.

Until 1970 almost all care provision was in the hands of public authorities: the City of Stockholm, the County (mainly responsible for health care) and the state. The forms of care were private foster homes and public institutions; with foster homes representing the larger part of care provision. In the late 70's and beginning of 80's private entrepreneurs started to provide care and services for children (and also adults). Most new care developed out of foster homes that expanded and became small institutions and group homes. This was the start of a market for care provision, which expanded slowly and came to a peak 1992, when it started to balance the demand in a rather harmonic way. Alongside the private providers, there are still some municipal residential care centers operating, mainly with the purpose to give short-term care and/or to prepare for foster home referrals. Stockholm is divided into 18 districts. The Social Assistance Office (SAO) at each district has its own budget for social services, allocated according to criteria such as social and economic needs. Each SAO is in charge of assessing needs and translating them into demands for service, for to purchase care and to pay for the care costs with their budgets. Care providers are private, and some of them NGOs. There are also some municipal residential care facilities that are handled by an Administrative Agency (Stockholm HVB) that provides care for children, both to the City of Stockholm and to some other 20 – 30 municipalities in the region. [1]

For reasons of economies of scale (saving money and concentrating skills in one office), Stockholm concentrates some of the purchasing functions into a central office, which acts as a broker for the districts. The central office (Bureau for Placement, a part of the Social Assistance Administration, City of Stockholm) actually negotiates the contracts with the care providers. To procure the care, the Broker announce a tender and gets around 85 bids among which less than half results in contracts. There are two types of contracts:

- long term contracts (1-3 years) for frequently used services (about 35 given out per year, based on demand forecasts). These specify a price and quantity to be purchased over the year, and
- short-term contracts, for infrequently used services, which are paid for as demand arises. The broker gives advice to the SAO concerning placements at these care facilities.

[1] The only state owned institutions today are meant for compulsory care of adult drug- and alcohol abusers and delinquent youngsters. This represents a minor proportion of all individuals in care (350 adults and 6-700 young delinquents) Some State or County owned institutions provide care for severely handicapped persons.

Box 2 (Continued)

The long-term contracts help to ensure a stable supply of services, as they lower the provider's risk thus reducing costs. They also insure that care is available throughout the city so that clients do not have to travel too far from their families. The short-term contracts provide flexibility.

The advantages of this system are:

- Competence and capacity is concentrated to one single agent (broker).
- The broker can act as a strong negotiator that can keep the costs on a reasonable level. This is helpful for small districts and municipalities.
- The broker has a good control over the supply in advance, which means one can avoid ad hoc, and panic driven decisions in single client cases.
- The experiences the broker gets from one provider can be used versus others. Mistakes don't have to be repeated too often.
- The skills in the broker office are helpful for both providers and the purchasers; they can rely on support and good advice. (Providers that are likely to provide sub standard can be kept out of care business.)
- The stable staffing of the broker's office can to some extent compensate for high staff turnover and lack of continuity on district level. T he broker stays in close contact with the social worker at the district concerned.
- The risk of an expensive long term contract is shared among districts.
- Economy of scale achieved, lowering unit cost of care (which cannot be achieved in a rather small district).

The disadvantages of this system are:

- Some districts may think that having a broker office is "centralism" and they try to set up own care organizations (they are free to do so, but few uses that opportunity)
- Capacity is not built up at the district level concerning the care market, since this is handled by the broker, although the social worker on district is encouraged and expected to stay in touch with his/her particular client during placement.
- It raises the price of care slightly since the fees pay a part of the costs for the broker office. But that extra cost is compensated for by the City's lower unit cost for care. .

The system also put an end to the "over planning" that was common in the old system. Districts had a tendency to over-estimate their needs of institutional resources as long as others paid these places.

The pros and cons outlined above indicate that small municipalities should preferably purchase care on a day to day basis for single clients, unless they can pool their resources and set up a broker to deal with the issue. Still – purchasing of care in that flexible way (day to day) does not mean that a market orientated system is out of reach. A provider can always sell its services to more than one municipality. The disadvantage is that a small municipality will hardly build good capacity in purchasing if these purchases are rare. (Who would dare to take a by-pass surgery at a small hospital that only does that kind of surgery every fifth year?)

An evaluation of this system was prepared in 1993-94. The results were positive. Overall, unit costs were lower for an acceptable level of quality. However, the implementation of the purchaser-provider system coincided with several other management changes and budget cuts in Stockholm city and county. As a result, it is difficult to distinguish between the effects of the different measures.[2]

[2] The evaluation was conducted by The National Board of Health and Welfare in Sweden and was published in the Report Series Active Follow Up 93/94, by Lead Economist Karin Mossler. The follow up study targeted the privatization effects in Stockholm municipality and county administration in general.

Table 3: Allocation of Functions in Stockholm

Purchaser (district)	Purchaser-Broker (central)	Providers
○ Assesses and prioritizes needs, makes a care plan, and secures client agreement and family support. ○ Rations financing. ○ Reviews service. recommendation from broker, accepts them or sends them back for further work. ○ Pays for care. ○ Reviews outcomes on client level, provide feedback to broker. ○ The ultimate responsibility for a client always rests with the purchaser.	*(1) Contracting*: ○ Agree with (make contracts on yearly basis) with providers. ○ Agree with (set a day price) with providers. ○ Manage the administration and the billing. *(2) Matching* (prescribing) ○ Match client to best care option and give a proposal back to the district. *(3) Quality monitoring*: ○ Assess and monitor the quality (on aggregated level). ○ Present outcome, costs and propose new contracts to the political board as well as termination of contracts no longer needed. ○ Keep informed about demand and supply and take initiatives to encourage provision of care that is needed.	○ Produces the quantity and quality of care at the price agreed. ○ Providers are required to submit to audits and monitoring indicators, including statistics showing costs, number of clients, outcomes etc. ○ Providers are responsible for their own training, development and all other measures that make them competitive and able to produce good quality care and services.[1]

1 All care provision is also monitored by The County Administration Board (a regional state function) and the National Board of Health and Welfare (a central state function).

PART II: OVERVIEW OF SOCIAL CARE PROVISION IN THE ECA REGION

SUMMARY OF SOCIAL CARE SITUATION

The legacy from the Soviet era was to provide care for vulnerable citizens in residential institutions. Today, most transition countries still use this approach, although projects aiming at replacing residential care – or parts of it – with community based non-residential alternatives are growing as well. This overview below is based on the experience gathered from a number of care related projects in the region. Anecdotal data has been collected from countries in the region to exemplify the current structures of care and services, how and by whom it is managed, its costs and financing. Note must be taken that the data are not comparable due to differences in reporting techniques as well as the time period the figures refer to. This chapter will focus mainly on children's situation.

Table 4: Children Age 0-3 in Infant Homes, 1989 and 1998

(Per hundred thousand 0-3 population)

Country	1989	1998	1989 – 1997 (percent change)
Czech Republic	533,0	571,7	3
Slovakia	191,7		44
Hungary	504,6	378,9	- 25
Bulgaria	873,8	1299,6	46
Romania		836,4	56
Estonia	149,9		115
Latvia	528,2	996,5	72
Lithuania	275,6	324,1	16
Belarus	169,4	325,6	75
Moldova	183,5	285,8	31
Russia	208,3	365,0	64
Armenia	13,2	23,4	68
Azerbaijan	35,5	27,0	-20
Georgia	75,7	79,9	-25
Kazakhstan	122,4	267,3	78

Source: MONEE project databases

The deteriorating economic conditions and the far reaching economic and political changes in the 1990s in ECA caused a major increase in poverty and vulnerability in the region. Between 1988 and 1998, absolute poverty rates increased from 2 percent of the population to 21 percent – an unprecedented 10-fold increase (World Bank, 2000). By 1997, real incomes were 30-60% of the recorded 1990 levels. Unemployment and poverty, especially among families with children, rose to levels not seen before in these countries. The transition brought all kinds of deprivation – from outright hunger to the disruption of previous norms and expectations for the social structure. Social protection needs increased along with poverty. However, most governments cut back cash and in-kind social supports in the face of major fiscal crises (caused in part by the downturn). Overall, the negative impact of the early years of the transition on people's lives, especially children, was unprecedented. (UNICEF, 1997; and 2000; World Bank, 2000).

Use of residential care is growing. One response to this poverty crisis in most countries in the region was a major increase in the number of children in residential care. This trend shows no sign of abating. Some of the countries place around 1 percent of their children in infant homes, while most countries show lower figures. These are high figures compared to Western Europe, both as a total number of children brought up out of their

families and as the number placed in residential care. The figure for Sweden is 0,5 percent of all children placed out of their families and the majority of these children are placed in foster homes.

Official data from concerned countries confirm that the number of children directed to care institutions increases every year and that only a small part of these children were placed in alternative care. This development continues despite that fact that countries are instituting changes in cash benefit systems to help families keep disabled children in their homes and that the share of funds allocated to non-residential care appears to be increasing.

Elderly, mentally and physically disabled people and children are the three big client groups. Children are either (a) orphans, (b) not orphans but nonetheless deprived of parental care, or (c) children with social problems; e.g. children not deprived of parental care but at risk for other reasons due to their own behavior and/or parental maltreatment. Poverty plays a role; some of the clients now institutionalized should not be in institutions if they were not poor or lacked someone who cared for them.[1] The commonly used term "social beds" indicates that residential care is used for clients who really should not be in care if they could be provided for in other ways.

Alternative care is growing. Ambitious work is going on in the region to develop community based care (see Box 3 below). These alternatives aim at helping with housing, and to give counseling and support to families and vulnerable people. The community based care is not only less expensive than residential care but also more cost effective, of the following reasons. The alternative care can in many cases postpone or prohibit a referral to residential care. It helps clients to cope with their situation after release from residential care. It also takes into account the client's own ability to function which has an impact on the costs for staff.

Alternative care forms are mainly used for elderly that can cope themselves with the support of a home-helper, but sometimes also for disabled. Home-helpers are available and fairly easily trained in many countries in the region, but home care has not become as professionalized as in Western countries. Guardianship and foster homes for children are increasing. Figures from Lithuania year 2001 indicate that alternative care for children covers 51 percent of total number of children in care. However, there are differences between countries. Some have come far in appointing guardians for children among which some would have been placed in residential care while other countries report less non-residential alternatives for children although it is a policy goal to give priority to services rendered at home and in other forms of non-residential care.[2] The financing forms are partly decisive for how this care develops. If one form of care is subsidized or even paid by state budget, it appears to expand.

Spending on care. If we look at the spending on residential and non-residential care for two of the countries in the ECA region, Latvia and Lithuania, the following picture emerges.

Table 5: Average Costs Per Year and Client for Residential and Non-residential Care

Client group	*Residential care*	*Non-residential care*
Elderly	3700 USD	1200 USD
Disabled	4340 USD	(*)
Children	4880 USD (**)	1300 USD

(*) Data not available (few disabled placed in non-residential care)
Source: Lithuania, 2000 and Latvia, 2000

[1] Tobis, 2000
[2] Foster-home is usually meant for short-term placements while guardianship is a long-term alternative care form.

Box 3: Examples of Family-focused Care Currently Operating in Transition Economies

- Day centers for support, counseling and service to elderly, risk families and disabled.
- "Meals on wheals" to give practical help with meals delivered at the door.
- Local services to families with disabled children or social problems.
- Help to children who have experienced violence or been deprived parental care.
- Crisis centers for individuals/families who encounter different kind of crisis.
- Guardianship for children instead of referrals to institutions.
- Half way houses and service-apartments in the interface between a residential care and a self-dependent life in society.
- Counseling centers
- Home help and advanced home help.
- Support to ex prisoners to help get back into society, find job and housing.
- Centers for battered woman and their children for short-term overnight facilities
- Group homes; small institutions that provide care and services to a certain client group.
- Adoption and foster care.
- Night shelters for homeless people for short-term placements.
- Rehabilitation training for physically disabled, assistance with handicap devises and handicap-equipment.
- Open programs and outreach activities for risk families.

Unit costs of residential care represents between 165 – 209 per cent of the GDP per capita whereas unit costs of non-residential care amounts to 51 – 55 percent of GDP per capita.

The differences between costs for residential and non- residential care are striking. However, one has to take into account that different methods to calculate the figures may over-emphasize the differences. Also – the large number of guardianships reported distorts the comparison since guardians have a low remuneration. However, guardianship must be considered as community based care because it allows the child to stay in a family and it is private. Other sources of information also confirm that the costs for newly developed alternative care services are lower than those for residential care.

Box 4: The Pitfalls Of Decentralization During Economic Decline : Lessons From Romania

In 1997, Romania transferred the responsibility for child protection to local governments, and in 1998, accelerated and the social sector decentralization process by transferring resources, responsibilities and accountabilities for many social and community services to local governments. In principle, the decentralization was designed to encourage local innovation and initiative, including the development of more community-based social care services. By 2000, local governments provided over 50% of the total government funding for social services (a larger share in social assistance in community services and a smaller share in other sectors such as health.)

Unfortunately, the reform became effective in the middle of a fiscal crisis. Between 1996 and 1999, GDP fell 13% and local government revenues fell even more. In 1998, local revenues were 25 percent below the 1996 level, and in 1999, 20% below. This revenue crisis, combined with what was at times an ad hoc distribution of functions and ownership, a lack of support for local administrative capacity (which was weak), and constantly changing policies on revenue transfers, resulted in an almost chaotic situation in social assistance in 1999-2000. Local governments were not able to cover the costs of the institutions the suddenly owned, and in some areas, conditions deteriorated sharply. In other cases, governments cut back on cash benefits, which caused

poor families with children to increase demand for institutional care (as this was all that was available). Fragmentation of social assistance policy, monitoring and oversight responsibilities across the national government reduced the scope for national leadership and support during this process. Local governments viewed decentralization not as an opportunity, but as the national government passing the pain down the line.

In some localities, the reforms had the desired effect of inducing system change. Some localities were able to cope by working with NGOs and outside assistance to (a) rationalize and cut back on institutional care, and (b) integrate the NGO sector effectively into the service network, providing more choice.

Romania has worked to address these problems. In late 1999, the national government intervened with emergency aid. A new Law on Social Assistance was draft to consolidate national functions and reduce overlapping roles and responsibilities, enhancing accountabilities. Beginning in 2001, local councils are required to fund residential care on a capitation basis, not an input basis, improving the incentives for reform. Romania's experience clearly shows the importance of a strategic approach to reform from the start, as well as the difficulty in implementing a reform at a time of declining revenues.

Source: World Bank, (2001); UNICEF, (2000)

FINANCING FRAMEWORK – ROLES AND RESPONSIBILITIES

Mostly monopoly – even after decentralization. Public authorities on different levels - state, regions/counties or municipalities - most commonly provide care. The non-governmental organizations (NGOs) share of the provision is still on a very small scale even if figures show that their part increases slowly. Most NGO provision is financed by private (donor) sources. There is rarely government quality monitoring. Private entrepreneurs in care provision are still unusual.

The financial implication of the monopoly system is that care provision is not being geared by client needs, it is supply driven. The fact that only a certain kind of care is available is decisive for how client needs are determined. Funds are not allocated among people in need, but among providers. The social worker (the agent) has more loyalty to the supplier (the monopoly) than to the client and the referring authority (municipality) has no incentives to make adequate need assessment to find out what best helps an individual. And if needs assessments are not being performed – or are poorly performed –no information feeds back to the supplier (institutions) concerning what needs that should be met and how to best meet them.

The ongoing political and fiscal decentralization has not changed this picture much. Where institutions have been decentralized the funding often remains centralized. Some alternative care – like guardianship – is financed by the national level, while most alternative care provision appears to rest with the municipalities. In a long-term perspective funds for alternative care have to be reallocated. If institutions are transferred to local level, the funds should go with it.

The table below shows the most common split
of tasks and responsibilities between state and the counties or the municipalities. The state often funds care and services of a more categorical type (severely disabled, blind and other similar groups), they also manage the care and are the owner of the facilities. The local governments are in most cases in charge of non-residential care, with a few exceptions; elderly in residential care are often the responsibility of local governments and the state is sometimes funding guardianship, making an attempt to cut back on referrals of children to residential care.

Table 6: Distribution of Financing Responsibilities by Target Group

Target group	Residential care	Funding	Alternative care	Funding
Children	Residential institutions	Mostly the state, but sometimes on the municipality budget	Foster homes Guardians Group homes Open activities	Mostly the municipal budget, but for guardians, state budget NGOs
Elderly	Homes for elderly	Mostly the municipalities but also the state	Home care Open activities	Mostly municipalities NGOs
Disabled	Residential institutions	State mostly	Open activities	Mostly municipalities NGOs

Input budgeting. The provider is usually financed by an input budget in such a way that the provider gets paid regardless of what is produced; e.g. the financing is not clearly related to the number of clients in care and length of time in care, let alone, the outcomes of care. The assumed costs for a projected number of clients are allocated on beforehand. Outcomes are not tracked and systematically analyzed which means that prices related to the outcome of care are unusual. The authority responsible for care and services is in most cases the owner of the care facility.

Funds are either allocated: (a) directly from the state treasury, (b) through an agency, or (c) from local resources, including central government equalization transfers, or (d) some combination of these. In some cases municipalities belonging to a
region contribute to the funding according to their size and demand for service facilities.

Weak or non-existent purchaser. There is no clear distinction made between purchasers and providers in the system. The pure form with one clearly identified purchaser who: (a) does the need assessment, (b) acts as a gate keeper, (c) refers clients to care, and (d) pays the fees on the one hand, and one equally clearly defined provider that (a) manages the care, and (b) gets paid by the fees, on the other, is not too common in the region. The following combinations of ownership, management, financing and power to decide about referrals can be seen (Table 7).

Since many institutions assume conflicting roles: ownership, management and provision, financing, and also referrals of clients, they have a strong influence over what clients to take in and discharge. This does not give incentives to produce good outcomes and to be cost-effective.

Throughout the region there are indeed purchaser – provider systems implemented, but they appear to either lack the two essential features that make them work adequately: (i) right to decide and (ii) obligation to pay; or they have more roles than they should. If the purchaser who makes the decision to refer a client to care does not finance the care they cannot ensure that need, as determined by the gatekeeper, is financed up to the budget constraint so that care is rationed properly.

Little outcome monitoring. There is no systematic tracking of outcomes of care and rather poor consciousness concerning the relationship between costs and outcomes. The absence of appropriate monitoring pushes economic considerations (who pays) in the foreground and makes these considerations more decisive for the choice of care than client's needs are. This also makes the follow up on results unimportant. If the purchaser

does not strive to find the care that can best meet client needs, why bother to find out if these needs have been met? And if this important element of evaluating outcomes of care is not in place, the development of best practice is hampered. There is little feedback to the institutions about what care is effective and without that information, it is difficult for the institutions to change and adapt to clients needs and develop best practice.

Table 7: Combinations of Institutional Roles in ECA

Owner	Manager	Financier	Referring clients	Combinations
X	X	X	X	1. Usually a state or municipality owned institution that decides which clients to serve. This type is predominating in the region.
		X	X	2. A municipality that purchases care from a provider (state or other), makes decisions to refer clients, and pay the fees. This is a clear purchaser, but rather unusual in the region.
X	X			3. A provider that owns and manages an institution and sell its services and is financed by the fees. This is a provider, also rare in the region.
			X	4. A municipality that refers clients to care that is paid by others, in most cases the state (or a region). This form is common.

Prioritization. We have little information about how prioritization is made. We can see – for example - that state financing of guardians has supported an expansion of this form of alternative care. But we lack full information about the day-to-day prioritization to ensure that the most needy are targeted and that care giving the best outcomes to the most reasonable price is used. In general, two factors seem to be important for setting priorities, one is the supply; if there is a place vacant, a client is likely to be referred to it. The second is the financing. Care that the referring authority does not have to pay for appears to be prioritized. Anecdotal evidence in Moldova and Armenia – to take two examples – clearly show that people that are poor, end up in institutional care. Where the resources are, children will go.

Financial statistics. Financial statistics generally do not show the true costs of care (alternative or residential) since capital and maintenance costs sometimes are financed separately. These costs – that are easy to forecast and put into the regular budget – are often covered by the funding authority in a separate budget. The decentralization has resulted in multiple pipe financing – usually all financing for state institutions comes from state budget and all costs for municipal institutions are covered by municipal funds. Money is not fungible between the two sources.

The part of the care costs that are paid by the client is usually a relatively small portion of the full costs. Most alternative care is provided free. For residential care, in most cases a pensioner pays from his/her pension to the care facility and the sum varies from almost the whole pension except a small sum that is kept as pocket money, to smaller amounts. In the perspective of the total costs for residential care, the contribution of the clients is insignificant. But the fact that some services are free of charge for the client is likely to increase the demand.

CONCLUSIONS

Confronted with a massive increase in poverty and social dislocation, countries increased the use institutional care. This has been an unfortunate waste of resources. It was fully understandable, however, as the current system for care and service delivery is not able to promote a variety of alternative care options and reach the targets set forth; e.g. the concepts for a good financial framework outlined in part I are not possible to fully apply. The balance between: (i) the needs of vulnerable people, (ii) what the gatekeeper social assistance office) finds most helpful for the client within the current budget constraint, and (iii) a supply of care at good quality and in appropriate quantity, is difficult to realize in the current system.

BOX 5: WHY IS THE NUMBER OF CHILDREN IN CARE GROWING IN LATVIA?

Latvia overall has experienced a 72 percent increase in residential care 1989-1999. However, the distribution has not been even nationwide. This is not surprising, as Latvia is a fiscally very decentralized country, and since 1995, the responsibility (ownership and operation) for most care facilities rests with local governments – in some cases with regional governments, and in some cases with municipalities. The Government's intent was that homes would be transferred to the municipalities from the regions which should have encouraged a market to develop. This did not always take place however. It should be noted that not all municipalities own a home even when the regions did give up control, as Latvia ahs over 400 municipalities. Municipalities are supposed to pay an output-based fee when they place a new client in another local government's facility (the mutual payment system). This payment system has been slow to develop.

In 2001, the Ministry of Social Welfare in Latvia commissioned a study on why in some areas, residential care is growing faster while others are meeting new needs with community care. The results were striking.

- Municipalities which have an institution tend to keep the institution full, in part in order to maintain employment. The rate of institutionalization is growing in these regions.
- Municipalities which do not have an institution have adopted one of two strategies. Some are building new institutions; others are developing more community care.
- In regions where the mutual payment system works well, community care grows faster.
- All localities cited lack of funds as the main constraint to the development of more community care. However, many see community care as an addition to the service basket, not a substitution

Latvia's experience demonstrates the difficulty of achieving results through a simple fiscal decentralization. A broader strategy is necessary, including a nationwide strategy for facilities consolidation and training program to develop the purchaser and gatekeeping functions. Improvements in standards are also necessary. Latvia's current strategy involves all of these activities.

(Source: Latvia, 2000)

Care and service provision is driven by supply, needs are not properly assessed and there are weak incentives to focus client needs. Costs – or rather who pays – appears to have too much impact on choices of care than it should and awareness that needs must be converted to demands, rationed and prioritized is low. Incentives to use alternative care are not good enough, many municipalities prefer to use the residential care available at no or little cost to their budget in order to save municipal funds for other needs. The purchasers do not generally pay fees, thus lacking one of the more important functions of an efficient purchaser. However, if financial incentives are put in place – as for guardians – it appears to change referral pattern for the better. Countries are caught in a vicious circle - the more money that goes in to residential care, the more the fiscal burden and the more difficult it is to find other – less expensive and more qualitative - solutions to peoples needs. The input budget system does not encourage competition, it limits the care mix and give few choices for client and purchaser, thus hampering the improvement of effective supply of care.

PART III: IMPLEMENTING A BETTER FRAMEWORK

Improvement in social care services – and ultimately in the life choices, opportunities, and welfare of vulnerable groups, requires changes in the financing framework as part of an overall reform. Such a change does not mean a shift from public financing for vulnerable groups into private financing, e.g. putting the burden of costs on the vulnerable families instead of on public authorities. The public's responsibility for vulnerable citizens should remain but it should take place within a better financing framework.

This section reviews the main aspects of the current system, which need to be changed. Several key issues need to be addressed. First, the purchasers need to be set up, with clear responsibility and incentives to serve the client, not the provider. Second, budgeting and financing procedures need to be changed to allow out-put oriented financing of providers. Third the tools for the agreement between

the purchaser and the provider need to be developed, including contracts, rules on pricing, and tendering. Fourth, existing providers need to be reformed, and new entrances facilitated.

SETTING UP THE PURCHASER

The table below shows – very simplified – the tasks for the purchases currently in place in the region, and the desired mix of functions that a purchaser ideally should have to be effective. A purchasing organization should be set up with the task to assess people's needs and to find the appropriate care and service for them. This organization should also manage the budget for the care it purchases. One cannot purchase unless one know what to buy, and what are the prices. Therefore the purchaser organization must be informed about the care market and the costs, in order to match client needs with the best care option available, residential or alternative care.

	Current system	Proposed system
Purchaser	▫ Meet with client and assess needs ▫ Match needs with supply ▫ Refer client to best available care ▫ Suggest areas where new supply is needed	▫ Meet with the client and assess needs ▫ Transfer needs into demands ▫ Ration care ▫ Work out a care plan with clear targets ▫ Refer client to best possible care ▫ Pay for the care (fees) ▫ Follow up on outcomes
Provider	▫ Take in client ▫ Work according to concept for supplier ▫ Get financed on input budget	▫ Take in client and work according to care plan ▫ Report back to purchaser ▫ Finance the care establishment on incoming fees

The purchaser's decisions to refer a client to care should be driven by a profound understanding of two things: what a client need and how these needs can best be met.

Establishing the needs is done in a need assessment procedure in which the social worker, the client himself, his family or/and other significant individuals participate.

Needs are not the same as demands and assessment of needs is a professional procedure of converting client needs into appropriate and affordable interventions. (The drug addict may express a need for drugs, but what the public sector is willing to finance is something quite different – a treatment to get off drugs.) The need assessment should result in a care plan identifying the client's weaknesses but also his/her capacity to contribute to a good outcome of the care. The purpose with care is not to "over-treat", just help with what the client cannot manage him/herself.

In pursuing the best option for meeting the client's needs, the purchaser should aim at a solution without moving the client out of his/her family and natural environment; e.g. it is better to support a family to care for its child, to help family members to keep an frail elderly parent at home, to provide home-help etc. Referrals to care – residential or alternative – should always be the last option.

One function of a good purchaser is to do the gate keeping to ensure that the client is referred to care only if he/she needs it, that the right form of care is used and that there is a plan for the care and clear targets for what to achieve and –not at least – how the client (in many cases) can be brought back to society one day. The gatekeeper must have the power to make the (right) need-driven decisions about care and – above all – have the money to pay for care purchased.

REFORMING BUDGETS

The current input based budget system is a legacy from the command economy and it does not promote the behavior and performance we like to encourage among care providers. Input budgets do not sufficiently focus on results of care. The new financing system has two basic elements: (a) the one who refer a client to care should pay the (publicly-financed) fees for this care, -- the single pipe -- and (b) the fee should be related to what is produced, to the outputs. If all costs for care and services are related to its value, to what is being produced, we call that an output-based payment system. This system gives the purchaser an incentive to buy best care at best price. The simplest form of output-based budgeting is a capitation system, where the same payment is made per client. More complex forms include fee for services, according to standardized diagnoses or outcomes.

New budgeting procedures may also include a guideline on the amount which should be spent for a certain type of client, to avoid cost runaway (see contracting, below). These guidelines will assist purchasers in designing affordable care plans, and clarify expectations from the client side on what services are available.

Output-based budgets may imply that some revenues have to be taken away from one level of government and given to another (the purchasing level). If governments stop paying for care and municipalities take over financing responsibilities governments have to hand over funds to municipalities. This may have to happen over time (see part IV). There are good models for how the shift of budgets can be done that safeguard an organized retreat from residential care at the same time as funds are being freed for development of community based care.

MAKING A MARKETPLACE: PRICES, TENDERING, CONTRACTING

Purchasing and budget reforms need to be complemented by the development of tools to regulate the purchaser-provider financial relationship. The first tool is an agreement on the costs for care supply. An economically sound institution should have all costs covered by the revenues it gets from its provision (producing and selling) of care and services. That includes not only recurrent costs but also capital costs. A part of the revenues should be set aside for future costs for maintenance, purchases of equipment, vehicles etc. If not, the institution will not be sustained.

	Current system	Proposed system
Financing	▫ Public authorities usually finance care at the institutions they run from their own budgets ▫ Most financing is according to an input based budget system	▫ The public authority (purchaser) that refers a client to care (municipality) is responsible for the financing or some or all of the costs ▫ The budget system is based on what a provider produces, e.g. per outputs, per capita, per bed and day etc. Global ceilings are set to avoid over-runs and guide rationing decisions.

A market system, and the purchaser – provider system means that prices for care and service provision are not set on beforehand. As we will discuss below, bidding for services and making contracts with providers will result in a price structure that is affordable for the purchaser to pay and enough for the provider to survive. Still, any purchaser must have an idea about what is a fair price on a care product and project the costs for the purchases needed.

	Current system	Proposed system
Prices	▫ (Implicit) prices set on input norms but not to cover all costs ▫ Revenues added over time from different sources ▫ Real costs unclear	▫ Explicit prices reflecting true costs ▫ Transparency and accountability
Tender and contracting	▫ Providers assigned through various budget systems ▫ No clear contracts exists ▫ New providers are being discriminated and are not encouraged to be a part of care provision	▫ A care assignment is regulated by a contract between purchaser and provider ▫ Contracts regulate what should be achieved and to what costs ▫ Call for tenders allow new providers to participate in care and service production.
Market	▫ No real market exists	▫ A marked set up on which resourceful professionals, public, NGOs and private, compete to deliver best possible care to lowest possible costs.

A tender procedure (when a purchaser identifies and mobilizes new providers) usually does not set out the price on beforehand. A purchasing organization issues a call for bids in a document specifying type of care, quality requirements, and quantity but not price. The tender document also discusses how contract will be made (over what period, etc.) The winning bid is the one that offers the best quality to the most reasonable price.

Contracts between a purchasers and providers are basically of two types. The first is a contract concerning just one individual client. This contract should regulate what results the care period is expected to give, the fees and what they include, conditions for payment, time in care, division of responsibilities between the open social assistance office and the care giver (issues like contacts with family, after care activities, follow up etc.) and a number of similar items. The goals for the client's care or service should be based on the care plan. The second type of contract is more appropriate for a purchaser that needs to purchase large amounts of care of the same kind. In such a case the purchaser can agree with a provider to use a fixed number of places for a fixed period or time (a year or more) and agree on a fee. The contract should include roughly the same items as the individual contract, but need to be more general. To make contracts for too long periods of time is not advisable; there is a risk that

the provider goes back to "business as usual" if he is not repeatedly submitted to competition. It could be helpful for the purchaser if a national agency or ministry (or the project work group) could work out a standard contract as guidance (see Bilson and Götestam, 2002).

LICENSING

Licensing sets the ground rules for who can participate in the tender. Once standards are put in place concerned parties (purchaser, providers, clients, relatives, social workers etc.) would have a fairly good idea about what to expect from a certain caregiver/provider. Standards for similar care facilities should be the same regardless of who runs the places, public authorities, NGOs or private providers. Minimum standards express the lowest threshold; standards of excellence raises the standards above this minimum level. Doing that, of course gives provider competitive advantages. This is an important element in the market structure. Standards are also a good guidance for how to train staff and management and they set the rules for the monitoring.

	Current system	Proposed system
Licensing	▪ Rules and regulation set the condition for care provision but the few private and NGO providers are usually not covered by the rules.	▪ Providers – regardless if they are public, NGO or privately managed - can be licensed if they meet the standards. ▪ Providers are monitored and corrected if they deviate from applying standards ▪ Licenses can be withdrawn

Most countries in Western Europe have different types of licensing system in place to safeguard qualitative care provision and to ensure that sub standard care is avoided. Basically, a provider that is able to meet the demands in the standards, could be licensed. Licenses can either be issued by a public authority or by a licensing agency that works on behalf of such public body. Issuing a license will always include an obligation to cancel the license if a caregiver no longer measures up to the license requirements.

REFORMING THE PROVIDERS

If countries adapt the principle of setting up contracts (individual or group) between the purchaser and provider, it should include the current residential institutions, or rather, those that will remain and continue to provide care and services. This change raises a number of issues. One is the legal status of a public institution. It may be difficult for a public institution that has had its revenue from an input based government budget to find itself submitted to competition on a care market and face the risk of losing its revenues due to poor performance, although this has been tried. It is critical for success that all institutions are in the market and face competition. If some kind of guarantee is given to the public institutions, that would immediately conflict with the very core in a competitive market since private providers will not get the guarantees. This issue will have to be faced clearly. One option is to have competition among public institutions first, to facilitate a consolidation and get the institutions and their owners used to the system.

	Current system	Proposed system
Provision of residential care	▪ Public sector provides care and services for disabled, elderly, orphans and children deprived of parental care.	▪ Some categorical residential care remains within the public sector but the provision of care and services is opened up for other providers, private and NGOs.

Provision of alternative care	▫ Public authorities (mostly municipalities) are in charge of community-based care and some NGOs and private providers are entering the provision. State active in guardian and some foster home care.	▫ Public authorities continue to provide alternative care, expand it and open up for more provision from NGOs and private entrepreneurs.

A market for care and service provision will not occur by itself, it has to be stimulated and supported at start and barriers to change has to be removed. In Western countries market provision has emerged in different ways. For example, (a) some home helpers working well together take over a part of a service in a community, change status from public entity to private firm and begin selling their services to their former employer, (b) a foster home expands its activities, takes in more children and become a small group-home for children, (c) some well trained social workers set up a family counseling unit, selling services to the municipality or to family courts, (d) a day nursery becomes privatized and is taken over by its staff. These are merely a few examples on the transition from public to private provision. The newly started private providers usually offer their services to the public authority concerned and a formal agreement – a contract – is set up. But it can also be a top down exercise in which top management decide to privatize some public units.

There will be a need to support the private and NGO sector to take on the challenge to develop community based care. Experiences from other countries in the region also speak for the necessity to support the community based care provision from the governmental level, once knowing what type of care to support. A plan for this has to be developed, including (i) mapping of provision of all care, (ii) assessing the need of care, (iii) projection of future demand of care, (iv) and working out an idea about a future service/care basket. Doing such plan would give a government (county, big municipality) a fairly good understanding of a future service mix, which – in turn – is a condition for the decision about what care and services to keep operative and what new care and services that are needed.

Standards (and to some extent also gate keeping) will have an impact on how a government (or a county/municipality) shapes the care and service structure. A basic element in any standard is to tell what an institution is meant for, what it shall do, in what way it can be helpful for clients and what type of clients that fit in. Having these two elements in place – (i) an idea about the new service mix (from the purchasing and budgeting reforms), and (ii) standards for quality in the service mix, will help a government to focus support to the new providers on the essentials. Or to put it the other way around – a government that does not know what it needs, how much and of what quality, will not be of any help to a growing market of providers; it would not know what new initiatives to promote and support. Neither would it know what are the obstacles for private and NGO provision.

How a service is valued has an impact on supply and demand. With growing consciousness about quality and outcomes, purchasers will demand services that produce a good outcome and meets the targets set out in care plans and referral agreements (contracts) between purchaser and provider. At the same time the institution that fails to deliver what has been agreed, will lose confidence and become less attractive on the care market. The demand for these services will decrease. This produces a good incentive for the provider to perform well, which – in turn – benefits the clients, the economy and the development of quality in care provision. [1]

Finally, it is important to repeat that a market for care and services must protect itself from low quality provision that may even be harmful for clients. Concerns have been raised that competition on lowest price will harm quality of care. But this problem – if it occurs – can be remedied. First, the licensing, standards for care,

[1] There are data sustaining the conclusion that institutions that are highly specialized have less possibilities to be competitive and survive on a privatized care market compared to multi-purpose centers that are flexible and can adapt to changes in demand

and monitoring will safeguard good enough quality. Only licensed safe providers should participate in the competition. Second, we have to assume that managers and staff have good ambitions - there is no reason why this should change as a result of the transition from one system to another. Third, a purchaser is not likely to buy poor products since low quality care does not give sustainable results, but rather results in recurrent needs of care, which in turn, is cost increasing. A competent purchaser will do the right choice from the first time

PART IV: HOW TO HANDLE THE TRANSITION

Making the transition to a new financing system will be demanding for all stakeholders. A number of transition problems emerge. Countries seeking to change the financing structure to a purchaser-provider model need to develop a sound project plan. The plan needs to be based on:

- an analysis of the current situation, which maps out what the economic roles are in the current system, the costs and who pays those costs;
- a proposed institutional structure for new system, specifying new roles, responsibilities, accountabilities and financial flows, and an analysis of the incentives;
- a needs assessment, projecting possible future demand scenarios with a change in practices towards more community and family centered care;
- a costing of the demand scenarios;
- a proposed new financial flow structure given (b) and (d);
- a facilities management plan; and
- and activity plan for project implementation.

In this section, we discuss the concepts involved in preparing such a project. Tools to help prepare this analysis are available on http://eurochild.gla.ac.uk/changing.

Changing the financial rules of the game is not enough to ensure better use of public and private resources toward better outcomes. Much more is needed. For example, all the work of setting up a purchaser and developing contracts will pay few dividends if reforms are not made in gate keeping, including developing better assessment and care planning tools. Likewise, contracts with providers should make reference to standards, which must be observed by contractors. Training programs are needed to ensure that staff really can deliver the quality promised in the standard. A monitoring system needs to be in place to protect clients. These issues are not dealt with in this section, but should be part of the overall reform strategy[2].

Social care reform strategies are often undertaken in the context of the need for public expenditure reduction. However, as noted above, the type of reform program discussed here is not likely to be expenditure reducing, both because new investments will be needed to develop new services and because the increased availability of community-based services will reveal unmet needs, increasing demand for those services. Indeed, an atmosphere of fiscal crisis is probably counterproductive for this type of reform. It is difficult to reach agreement among stakeholder on new roles and responsibilities as budgets are being sliced. It is better to develop the reform plan in line with available financing. Public demand for social care rises with national income (all other variables constant) so it is reasonable to expect that as income rises, social care will absorb a constant or growing share of expenditures. Reform is, therefore, important, as it makes it possible to serve more clients with better quality care and reduce the harm done by residential care.

ANALYZING THE CURRENT SYSTEM

A reform plan starts with an analysis of current expenditures and assets. This includes: total expenditures, unit costs, and a sources and uses of funds matrix. As noted above, all costs need to be considered, including

[2] See Harwin and Bilson, 2002; Bilson and Gotestam, 2002; and UNICEF 2000 and 2001 for discussion of comprehensive reform issues.

opportunity costs of capital. The reform team needs to work with the current providers to prepare this data. Worksheets can be developed to collect the data, which is then aggregated across the country (or across regions). A rough assessment of the balance sheet (valuation) for each provider can also be developed.

Table 8: Measuring Total Costs – An Example

A. Recurrent municipal costs per year	**Costs residential care**	**Costs non-residential care**
Wages excluding Tax		
Tax		
Office – administration, other consumable materials		
Premises		
Maintenance of premises		
Utilities (electricity, heating)		
Car use, car maintenance, travel		
Catering		
Miscellaneous		
Other recurrent costs		
TOTAL		

B. Capital costs	**Costs residential care**	**Costs non-residential care**
Building		
Office hardware and audio equipment		
Furniture		
Special equipment (medical, training etc.)		
Kitchen equipment		
Cars		
Interests (breakdown on x years)		
Other capital costs		
Total		

C. Indirect costs	***Costs residential care***	***Costs non-residential care***
Social Assistance Office's (SAO) for need assessment, care planning and referral of clients.		
SOA costs for having contact with client during care		
SOA costs for follow up on client outcome		
SAO costs for preparing and maintaining after care arrangements		
SAO costs for keeping contact with family during placement of client		
Opportunity costs (clients go back to work, support family and pay taxes)		

The reform team also needs an assessment of utilization by target group based on the demographics of clients, rates of treatment by demographics and geography, etc. For example, what percent of children in each age group are clients? Of what type of service? With what diagnosis (reason for entering the system)? It is useful to analyze this by region, by income group, and by ethnic group or any other important determinant of socio-economic status.

DEVELOP THE NEW INSTITUTIONAL STRUCTURE

The next step is to map out the current and new institutional structure, using the functions map in part III above. It is easiest to start with the purchaser. Which functions of the purchaser are currently being done? Which ones are missing? Given current and proposed political and fiscal decentralization, what level of government could have this responsibility? It may be useful to develop options, and consider for each option, how radical a change from current practice this would imply. It is also important to consider the number of clients to be served in each purchasing unit, based initially on the above analysis of rates of utilization, and the number of transactions with different levels of government a change would involve. Too many transactions can be expensive. In the case of too many small municipalities, one proposal could be to force them to work together as in the Stockholm model. Finally, what functions are best performed nationally? For example, should the national government make up a model contract? These issues need to be considered as well.

This analysis should also consider the current ownership of the provider structure. If the intention is to close or consolidate facilities, are the owners prepared to undertake such a change? If the owners are small local governments, such a change may not be possible. This would imply a further step in the reform – transferring ownership.

NEEDS ASSESSMENT, COSTING AND PROJECTION OF FINANCIAL FLOWS

One of the first questions the Ministry of Finance asks about any reform is – what will it cost? As the purpose of the financing reform is to shift clients and money toward more higher value uses (community care, for example), projection of future costs should not be based on current utilization patterns, but new ones. This is not easy to do, as it will depend in part on how quickly the provider sector can respond. One approach is to make a simple projection of the number of people in each key risk group in ten years. Then, using utilization coefficients for a country, which does not have a tradition of institutional care, a project utilization pattern can be developed. Looking at this pattern, what kind of facilities change does this involve? Is such a change possible? Some adjustment of the projections may need to take place, based on the distance between the current utilization and the desired utilization to reflect an appropriate speed of adjustment. A trend then needs to be projected between the current utilization and the future utilization to get annual demand estimates.

Using existing unit costs (based on full capital cost), and the above demand forecast, an annual budget projection for this new pattern could be formulated. This initial assessment will not include the costs of restructuring, however. These will need to be calculated later. As a result, the cost estimate at this stage will be an under-estimate of likely costs.

The final step in the projection of costs is to map the annual budget forecasts into financial flows from the purchasers to the provider, by type of facility and ownership. This will show the winners and losers. It will give some idea of what are the resource re-allocation needs in order for the purchasers to have the funds to purchase. It may also show which facilities will be in deficit, providing a basis for the next stage of the operation.

FACILITIES DEVELOPMENT AND MANAGEMENT PLAN

The next step is to use the projections above to develop a facilities master plan. It is not necessary to map out all the new community-based options which should be developed. Many of these will be developed in the community, based on the community needs. Often the facilities will be multi-purpose centers, serving more than one type of client. For example, family counseling and open family programs can be combined with foster care and guardian support, and needs assessment. NGOs may be contracted to develop the services within the center.

The main purpose the master plan is to target existing residential facilities for bed reduction or closure. It is critical that a plan be developed and agreed to restructure institutions at an early stage in the project. Unoccupied beds have to be paid by someone. As purchasers start buying less residential care beds, the institution will have to charge more for the full beds to cover costs. This will push up costs in the system overall. The facility master plan should be discussed with the owners and managers of the facility. All stakeholders should agree with the plan. Implementation of the plan should include staff and management training, and a plan for handling redundant staff. It is most likely that the plan will show the need of cutting back on residential care and developing new community based care.

When Western Europe countries implemented the purchaser – provider system in mid 90's, some managers submitted their own public entities (care facilities) to competition as a technique to distinguish the best from the ones producing sub standard. Letting public entities compete is one way to do the cut back and the process showed that many public entities were over budgeted. Another way is to assess the entities to see which of them that provide good quality to best price, and simply close down the other, or restructure them.

DEVELOP A PROJECT PLAN

With all these analyses in hand, the project team is ready to develop a project plan. Key elements of the plan should include:

1. Preparation of the legislative framework for the new financing framework:

   - new rules on fiscal transfers to ensure adequate funding goes to the purchasers, and that funding can go to providers on an outcome basis
   - remove obstacles for NGO and private providers
   - permit pilots and experiments
   - enshrining the new roles and accountabilities into legislation, including the power of the central authority to monitor all providers

2. Training plans are needed around the new functions and accountabilities for all public officials, as well as for NGO and potential private providers (especially important at an early stage for purchasers/gatekeepers). For example:

   - Everyone needs training in standards and licensing procedures.
   - Purchasers need training in care planning, using new tools.
   - Purchasers and financial authorities need training in output budgeting and contracting.
   - Support needs to be given to providers.
   - On demand support is also helpful.

3. Develop adequate financial management system in purchasers and providers. This is probably a separate project. Providers and purchasers can be required to buy a national system (but financing for this investment will be needed).

4. Develop model contract for purchasers, test it.

5. Consider how to assist community care providers to develop new services (investment financing, training, etc.). Consult with NGOs, as they could provide some support and financing.

6. Make sequenced activity plan, including plan for piloting purchasing arrangements (either de facto or real). Indicators of success need to be specified.

7. A key subproject will be the implementation of the facilities management plan. Funding for this will be required in advance.

CONCLUDING NOTE

This paper has reviewed the concept of a financing framework for social care – its function in a pluralistic, decentralized political system and a market economy. We have discussed the approaches used by OECD countries to modify institutional roles in order to improve incentives for quality, client service, and efficiency. Unsatisfied with a purely public system, yet aware of inherent failures of unfunded and unregulated private system, OECD countries have adopted forms of the purchaser-provider system pioneered in health. This approach has been judged to be successful. Two country case studies discussed how systems work in practice in Western Europe.

Despite widespread recognition of harmful nature of public residential care for children, use of this service continues to grow in ECA. The legacy of past use of this service model explains part of the trend, but the lack of financing reforms is a contributing factor, as in most countries, all fiscal incentives at the local level point to using institutions when children are in need instead of shoring up families. Countries such as Romania have been courageously trying to implement reforms in the financing system, However, these efforts have at times been hampered by a lack of an overall strategy, causing even more stresses in the system. In this paper, we have outlined the building blocks for a more comprehensive approach. As with any change project, the time frame has to be realistic, and coordinated with the ability of the system to change.

Money is – after all – an effective lever for changing ones mind (and eventually policies and lives for vulnerable people). Few of us spend our money on something we find worthless, most of us like the idea that good performance shall be rewarded. Yet, these simple and fundamental features guiding our private life are not in place in the overall system. We think that understanding of these fundamentals will be driving forces for change. A system-wide change effort will not be an easy task. Nonetheless, international contacts have led policy makers and system managers to become more aware of other practices, and this has fostered new attitudes with an enthusiasm for change, which will be an asset in the years to come.

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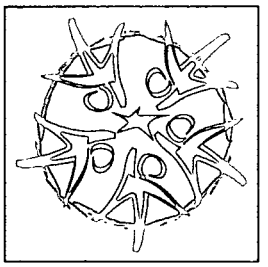

Summary Findings

A legacy of the command economy in Central and Eastern Europe and the former Soviet Union is a social protection system that emphasizes institutional care for vulnerable individuals. It has been well established that in many cases institutionalization can be more expensive per client served and produce inferior welfare outcomes than more inclusive approaches designed to support individuals within their families and communities. But countries seeking to change the model of services face a number of financial constraints, including redirecting resources away from institutions. How can countries develop the new programs in an affordable manner? How should they change the financing flows to support the new options, without putting the burden of financing on the vulnerable themselves? The objective of this paper is to provide a framework to help countries re-orient their financing systems for social care. The paper first reviews key concepts in social care financing and then applies them to the problem of changing social care models in ECA countries.

HUMAN DEVELOPMENT NETWORK